November 2017

Aloha to you and your ‘Ohana! On behalf of the American Medical Association Medical Student Section (AMA-MSS) Governing Council, we welcome you to the 2017 AMA Medical Student Section Interim Meeting at the Hawaii Convention Center from Thursday, November 9, to Saturday, November 11.

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

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

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

**Keynote speakers**
- David O. Barbe, MD, MHA President, AMA: Address to MSS Assembly
  - Friday, Nov. 10, 3:15pm | Ballroom 313 A-C
- Susan E. Skochelak, MD, MPH, Group Vice President, AMA Medical Education: Accelerating Change in Medical Education Update
  - Friday, Nov. 10, 4:30pm | Ballroom 313 A-C

**Featured education programs**
- Surviving an Epidemic: The Opioid Crisis of Today and Tomorrow
  - Learn more about the opioid crisis in America and steps you can take to help combat the opioid epidemic in your community.
    - Thursday, Nov. 9 | 4:00-5:30pm | Room 310
- Social Determinants of Health: Native Hawaiians
  - Join Hawaii Senator Josh Green, MD as he leads a discussion on traditional Hawaiian health care practices along with the social determinants of health of Native Hawaiians.
    - Friday, Nov. 10 | 1:00-2:00pm | Room 310
- Exploring Implicit Bias & Its Implications in Health Care
  - Hear from Justin Levinson, JD, a leading implicit bias researcher, as he discusses how implicit bias affects our own lives and future careers as physicians.
    - Friday, Nov. 10 | 3:00-4:00pm | Room 310
- Meet and greet: Edward H. Livingston, MD, FACS, AGAF, Deputy Editor, JAMA
  - Dr. Livingston will be available to meet researchers and answer their questions about the publishing process in the AMA Research Symposium exhibition hall.
    - Friday, Nov. 10 | 4:00-6:00pm | Exhibit Hall III

**Orientation for AMA-MSS Opportunities/First-Time Attendees**
Is this your first AMA Medical Student Section Meeting? Then you won’t want to miss the Orientation! Here you will learn about the AMA, how medical students make an impact on a local and national level, what to expect at the meeting, resolution writing, and parliamentary procedure.
- Thursday, November 9 | 5:30-7:00pm | Ballroom 313 A-C

**Featured Joint Section education programs**
- Being present: Physician wellness and mindfulness
  - Professional pressures and stress can lead to burnout, which can have an impact on organizational productivity, morale, costs and the quality of care being delivered. This session will provide you with ways you can address burnout individually and organizationally.
    - Saturday, November 11 | 9:00–10:00am | Room 320
- Achieving health equity through organized medicine as physician leaders
  - Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health care on the basis of their race, ethnicity, gender, gender identity, socioeconomic status, and sexual orientation. After participating in this session, you will learn about how you can integrate effective interventions, new techniques and patient considerations in order to mitigate and eliminate health disparities.
    - Saturday, November 11 | 11:20am–12:20pm | Room 315

**AMA Minority Affairs Section (AMA-MAS) reception and business meeting**
The keynote address, “How family-centered care helps Hawaiian healthcare meet the needs of a diverse patient population," will be delivered by Maile Taulii, PhD, MPH, assistant professor of native Hawaiian and indigenous health at the University of Hawaii-Manoa. Dr. Taulii’s presentation will focus on research and recent efforts to develop an ‘Ohana Centered model for health care delivery that is rooted in Native Hawaiian values. This work focuses on moving from patient centered care to ‘Ohana Centered care with the goal to assist patients in receiving the best individual care and disease prevention, and also receive advice and assistance in keeping their entire ‘Ohana healthy, from their kupuna (elders) to their unborn keiki (children) and everyone in between. The goal of this culturally respectful delivery model is to prevent disease, maintain health, prepare for the next generation, and help the kupuna ease gracefully into the time of hala, or the passing from this life into the next.
- Friday, Nov. 10 | 4:30-6:30pm | Hilton Hawaiian Village, Rainbow 3

**LGBTQ and Allies reception and caucus**
Hosted by the AMA Advisory Committee on LGBTQ Issues (AMA-LGBTQ)
The program will feature a panel discussion, “Walking the walk: How to navigate LGBTQ community engagement and social justice in medicine,” including family physician David McEwan, MD (moderator); pediatrician Bob Bidwell, MD (Kapiolani Medical Center for Women and Children); internist Jennifer Frank, MD (University of Hawaii, Manoa, University Health Services); internist Cyril Goshima, MD; and internist physician Drew Kovach, MD. Panelists will share perspectives on medicine and community engagement as a form of social activism to
achieve health justice. They will discuss their decades-long practice of medicine through public health and legal crises (e.g. AIDS epidemic, same-gender marriage) in the Hawaiian LGBTQ community and how it led to improved health and wellness today, as well as for future generations.

- Friday, Nov. 10 | 5:30-7:30pm | Hilton Hawaiian Village, Tapa 1

**AMA Foundation leadership and mentoring focus groups**

AMA Foundation is launching a Leadership Development Institute dedicated to cultivating a diverse cohort of aspiring leaders who are committed to serving the needs of their communities and improving the nation's health. As part of this, AMAF will be hosting informal focus groups for medical students interested in becoming mentors. The student focus groups invite feedback on what students would like to see in a leadership and mentoring program and will be used to develop curriculum for the Institute. Groups for students will meet at the following times at the Hilton Hawaiian Village:

- Thursday, Nov. 9 | 4:00-5:00pm | Iolani 6/7
- Friday, Nov. 10 | 8:00-9:00am | Iolani 3
- Sunday, Nov. 12 | 8:00-9:00am | Iolani 3

**Shuttle buses between Hilton and Convention Center**

Bus transportation will be available between the Hilton Hawaiian Village and the Hawaii Convention Center. Buses will depart the Hilton from the Tapa Tower bus terminal and depart each location at 15 minute intervals.

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, Nov. 9</td>
<td>10:00am</td>
<td>Tapa Tower Bus Terminal</td>
</tr>
<tr>
<td>Friday, Nov. 10</td>
<td>6:00am</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Saturday, Nov. 11</td>
<td>5:00am</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Sunday, Nov. 12</td>
<td>5:00am</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Monday, Nov. 13</td>
<td>6:00am</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Tuesday, Nov. 14</td>
<td>6:00am</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Saturday, Nov. 9</td>
<td>10:00pm</td>
<td>Tapa Tower Bus Terminal</td>
</tr>
<tr>
<td>Friday, Nov. 10</td>
<td>9:30pm</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Saturday, Nov. 11</td>
<td>8:00pm</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Sunday, Nov. 12</td>
<td>7:30pm</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Monday, Nov. 13</td>
<td>8:00pm</td>
<td>Convention Center</td>
</tr>
<tr>
<td>Tuesday, Nov. 14</td>
<td>1:30pm</td>
<td>Convention Center</td>
</tr>
</tbody>
</table>

**Convention Center concession stand**

The Hawaii Convention Center features a concession stand on the third level. It will be open during the following hours (subject to early closure):

- Saturday, Nov. 11 | 7:00am-2:00pm
- Sunday, Nov. 12   | 7:00am-2:00pm
- Monday, Nov. 13   | 7:00am-2:00pm
- Tuesday, Nov. 14  | 7:00-11:00am

**Dress code**

Business casual is appropriate for the Meeting, including reference committee hearings. We do ask that business attire be worn by those seated on the days during the AMA House of Delegates business sessions. This includes reports of the reference committees.
Elections
Elections will begin promptly on Saturday, November 11 at 7:30am – please ensure your delegate(s) are present to cast their vote. Assembly will resume sharply at 8:00am. Carefully review the personal statements and curriculum vitae that the candidates have submitted in the Election Manual. In addition to these materials, there will be an informal Candidate Forum on Friday, November 10 at 7:30-8:00am in Ballroom 313 A-C to meet the candidates running for AMA-MSS Governing Council Chair-Elect and AMA Board of Trustees Student Member.

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

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

Sincerely,

Anna Yap
Speaker, AMA -MSS Governing Council

Jay Llaniguez, MS
Vice Speaker, AMA-MSS Governing Council
Aloha new participants!

2017 AMA Interim Meeting
Hawai‘i Convention Center, Honolulu

NOV. 9–11
Interest-specific educational sessions, AMA Research Symposium and networking events

NOV. 11–14
AMA House of Delegates (policymaking meetings, open hearings and education)

Aloha new participants!

We’re glad you’re here!

The American Medical Association is pleased you are joining us for our 2017 Interim Meeting—where all of organized medicine assembles at the same time and place.

As a new participant, this brochure will help you navigate the meeting and better understand the variety of experiences you can take part in while you are here. We encourage you to visit our Information Desk, located outside the Kamehameha Exhibit Hall II, for additional personal assistance.

Visit the Information Desk for personal assistance.
(outside the Kamehameha Exhibit Hall II near registration)

AMA exhibit: Stop by to get your free gift and discover what’s new for AMA members!

Located just outside the Kalakaua Ballroom, the AMA exhibit is the place to:
• Post your photos on one of the AMA digital communities
• View digital resources and receive personal assistance
• Pick up your free gift!

Visit the Information Desk for personal assistance.
(outside the Kamehameha Exhibit Hall II near registration)

Download “AMA Meetings” app
(Apple and Android)

WiFi: aloha2017
Password: aloha2017

#AMAmtg

AMA exhibit: Stop by to get your free gift and discover what’s new for AMA members!

Located just outside the Kalakaua Ballroom, the AMA exhibit is the place to:
• Post your photos on one of the AMA digital communities
• View digital resources and receive personal assistance
• Pick up your free gift!

Visit the Information Desk for personal assistance.
(outside the Kamehameha Exhibit Hall II near registration)

Download “AMA Meetings” app
(Apple and Android)

WiFi: aloha2017
Password: aloha2017

#AMAmtg

© 2017 American Medical Association. All rights reserved. TBI:17:152326:300:10/17
Orientation

Things to know about the meeting and related events

AMA House of Delegates Interim Meeting
- Officially begins at 2 p.m., Saturday, Nov. 11, and is scheduled to adjourn no later than noon Tuesday, Nov. 14 (note: actual adjournment time and date, which can vary slightly, is determined by when the AMA House of Delegates formally concludes its business)
- Democratic process; forum for robust, respectful debate that establishes AMA policy positions and directs some actions and activities
- 555 delegates represent all 50 U.S. states and territorial medical associations, and nearly 120 medical specialty societies, lifestyle and interest-specific groups, as well as the armed services, Veterans Administration and Public Health Service (note: non-delegate registered attendees will find open seating in the back third of the Kamehameha Exhibit Hall II)

The AMA’s 11 interest-specific groups and their respective meetings and activities
- Represent and bring forward the ideas, issues and policy recommendations of their respective constituents
- The following groups conduct and conclude the majority of their official meetings and activities before the 2 p.m., Saturday, Nov. 11, opening session of the AMA House of Delegates Interim Meeting (note: because many meetings and activities overlap, we encourage you to refer to the “AMA Meetings” app or visit the Information Desk)
  - Academic Physicians Section (APS)
  - Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Issues
  - Integrated Physician Practice Section (IPPS)
  - International Medical Graduates Section (IMGS)
  - Medical Student Section (MSS)
  - Minority Affairs Section (MAS)
  - Organized Medical Staff Section (OMSS)
  - Resident and Fellow Section (RFS)
  - Senior Physicians Section (SPS)
  - Women Physicians Section (WPS)
  - Young Physicians Section (YPS)

AMA Board of Trustees
- Principal governing and strategic planning body; takes actions based on policy/directives of the AMA House of Delegates
- Twenty-one members (including student, resident, young physician and public member representatives)

Navigation

Finding your way around the hotel and hearings

Open hearings: Reference committee hearings
8:30 a.m.–12:30 p.m., Sunday, Nov. 12
AMA House of Delegates will consider more than 100 resolutions and reports that fit the advocacy theme of the Interim Meeting. If the resolution is accepted, each resolution will be referred to one of the following reference committees that will listen to members’ comments and then recommend how each item should be acted upon by voting delegates.
- Reference Committee on Amendments to Constitution and Bylaws
- Reference Committee B (legislation, legal and regulatory issues)
- Reference Committee F (AMA finance and governance)
- Reference Committee J (advocacy related to medical service, practice and insurance)
- Reference Committee K (advocacy related to medical education, science, public health and related topics)

Closed hearings: AMA councils
The following councils study and submit recommendations related to the business of the AMA House of Delegates:
- Reference Committee D (advocacy related to health care policy)
- Reference Committee E (advocacy related to health care access and utilization)
- Reference Committee F (AMA finance and governance)
- Reference Committee G (medical education and academic affairs)
- Reference Committee H (practice and professional affairs)
- Reference Committee I (research and science)
- Reference Committee J (legislation, legal and regulatory issues)
- Reference Committee K (advocacy related to medical education, science, public health and related topics)
- Reference Committee L (advocacy related to managed care)
- Reference Committee M (advocacy related to medical service, practice and insurance)
- Reference Committee N (advocacy related to military medical care)
- Reference Committee O (advocacy related to medical education, science, public health and related topics)
- Reference Committee P (advocacy related to medical education, science, public health and related topics)
- Reference Committee Q (advocacy related to medical education, science, public health and related topics)
- Reference Committee R (advocacy related to medical education, science, public health and related topics)
- Reference Committee S (advocacy related to medical education, science, public health and related topics)
- Reference Committee T (advocacy related to medical education, science, public health and related topics)
- Reference Committee U (advocacy related to medical education, science, public health and related topics)
- Reference Committee V (advocacy related to medical education, science, public health and related topics)
- Reference Committee W (advocacy related to medical education, science, public health and related topics)
- Reference Committee X (advocacy related to medical education, science, public health and related topics)
- Reference Committee Y (advocacy related to medical education, science, public health and related topics)
- Reference Committee Z (advocacy related to medical education, science, public health and related topics)

A few rules for the road
AMA members, guests and observers are welcome to attend:
- All reference committee sessions (AMA members have the right to comment; nonmembers or non-physicians may speak with permission of the chair)
- All educational sessions (including those offering CME)
- All open sessions of the AMA House of Delegates and interest-specific groups

Within the AMA House of Delegates sessions:
- Only certified delegates or alternate delegates temporarily credentialed as delegates may speak from the floor or vote

Education sessions
- Numerous, concurrent educational sessions and events offered with many sessions certified for CME credit (sponsored by various entities)
- All sessions and events are open to all meeting attendees unless designated as a “Governing Council,” “Executive Session” or “Closed Session” (be sure to check door signage before entering room)
- AMA and medical society staff are present at every session/event to help
- Please check-in with staff and sign in if you have not pre-registered for that session; claim CME credit by Dec. 31, 2017
2017 AMA Medical Student Section Interim Meeting
Hawaii Convention Center
Honolulu, Hawaii
November 9-11

Medical Student Section Agenda

Registration 3:00–8:00pm | Hawaii Convention Center

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
</table>
| 3:00–4:00pm   | **Advocacy Workshop: The Opioid Epidemic**
                Guest speakers: William Estes, Government Relations Advocacy Fellow, AMA | Ballroom 313A-C   |
                | Joy Lee, Member, AMA Council on Constitution and Bylaws                     |                   |
| 4:00–5:30pm   | **Surviving an Epidemic: The Opioid Crisis of Today and Tomorrow**
                Guest speaker: Scott Miscovich, MD, Family Physician; Chairman, Hawaii Opioid | Ballroom 313A-C   |
                | Overdose Leadership Action Workgroup (HO’OLA)                              |                   |
| 5:30–7:00pm   | **Welcome to Interim 2017: Orientation**
                Presenters: Anna Yap, AMA-MSS Speaker & Jay Llaniguez, MS, AMA-MSS Vice | Ballroom 313A-C   |
                | Speaker                                                                    |                   |
| 7:00–9:00pm   | **AMA-MSS Region Business Meetings**
                Region 1: 310 | Region 2: 317B | Region 3: 318A | Region 4: 319A
                Region 5: 320 | Region 6: 317A | Region 7: 313A-C | see description |

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

**Region 2**
Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin

**Region 3**
Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas

**Region 4**
Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee

**Region 5**
Indiana, Kentucky, Michigan, Ohio, West Virginia

**Region 6**
Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia

**Region 7**
Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
### Friday, November 10

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-7:30am</td>
<td>Delegate Credentialing</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>7:30-8:00am</td>
<td>Candidate Forum</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>8:00-9:30am</td>
<td><strong>AMA-MSS Opening Assembly</strong></td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td></td>
<td>AMA-MSS Chair Address, Helene Nepomuceno, AMA Board of Trustees Update, Karthik V. Sarma, MS Nominations, Candidate speeches, Extractions</td>
<td></td>
</tr>
<tr>
<td>8:00-9:00am</td>
<td><strong>LGBTQI+ Research: What Do We Know and What Don’t We Know?</strong></td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Carl Streed, MD, Immediate Past Chair, AMA Adv. Comm. on LGBTQ Issues; Fellow, Div. of Gen. Internal Med &amp; Primary Care, Brigham &amp; Women's Hospital</td>
<td></td>
</tr>
<tr>
<td>9:00-10:00am</td>
<td><strong>Recommendations for treating transgender patients</strong></td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Erick Eiting, MD, AMA-YPs Rep., AMA Adv. Comm. on LGBTQ Issues; Dir. of Emer. Med., Mount Sinai Beth Israel</td>
<td></td>
</tr>
<tr>
<td>9:30-11:30am</td>
<td><strong>AMA-MSS Region Policy Meetings</strong></td>
<td>see description</td>
</tr>
<tr>
<td>10:00-11:00am</td>
<td><strong>Rights: What Are They And Who Ensures They Are Protected?</strong></td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Frank Clark, MD, FAPA, AMA-MA Chair; Geriatric Psychiatrist; Adjunct Asst. Prof. of Psychiatry &amp; Behavioral Med., VA Tech Carilion SOM</td>
<td></td>
</tr>
<tr>
<td>12:00-12:30pm</td>
<td>Delegate Credentialing</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>12:30-3:00pm</td>
<td><strong>AMA-MSS General Assembly</strong></td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td></td>
<td>Voting on MSS Reference Committee Report</td>
<td></td>
</tr>
<tr>
<td>1:00-2:00pm</td>
<td><strong>Social Determinants of Health: Native Hawaiians</strong></td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Josh Green, MD, Senator, District 3, Hawaii State Senate, Hawaii State Capitol</td>
<td></td>
</tr>
<tr>
<td>2:00-3:00pm</td>
<td><strong>Healthcare’s hidden victims: Addressing sex trafficking in our communities</strong></td>
<td>Room 310</td>
</tr>
<tr>
<td>1:00-3:00pm</td>
<td><strong>15th Annual Research Symposium</strong></td>
<td>Kamehameha Hall III</td>
</tr>
<tr>
<td></td>
<td>Participant check-in/poster set up</td>
<td>Room 311 Room 318A Room 318A Kamehameha Hall III Kamehameha Hall III</td>
</tr>
<tr>
<td></td>
<td>Education session, Edward Livingston, MD, FACS, AGAF, Deputy Editor, JAMA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Podium presenter set up</td>
<td></td>
</tr>
<tr>
<td>4:00-5:00pm</td>
<td>Podium presentations</td>
<td></td>
</tr>
<tr>
<td>4:00-6:00pm</td>
<td>Poster presentations</td>
<td></td>
</tr>
<tr>
<td>4:00-6:00pm</td>
<td>Meet and Greet with Edward Livingston, MD, FACS, AGAF, Deputy Editor, JAMA</td>
<td></td>
</tr>
<tr>
<td>3:15-5:30pm</td>
<td><strong>AMA-MSS General Assembly</strong></td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td></td>
<td>AMA President Address, David O. Barbe, MD, MHA, 3:15pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMA MedEd Update, Susan E. Skochelak, MD, MPH, Medical Education Group Vice President, 4:30pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Voting on MSS Reference Committee Report</td>
<td></td>
</tr>
</tbody>
</table>
**Friday, November 10 (continued)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00-4:00pm</td>
<td>Exploring Implicit Bias &amp; Its Implications in Health Care</td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Justin D. Levinson, JD, Prof. of Law, Univ. of Hawai‘i at Mānoa, William S. Richardson School of Law</td>
<td></td>
</tr>
<tr>
<td>4:00-5:00pm</td>
<td>International Comparative Health Systems</td>
<td>Room 310</td>
</tr>
<tr>
<td>5:00-6:00pm</td>
<td>Team-based Communication in Healthcare 101</td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Guest speaker: Glenn Loomis, MD, Chair, Council on Long Range Planning &amp; Development, AMA</td>
<td></td>
</tr>
<tr>
<td>6:00-8:00pm</td>
<td>AMA-MSS Region Business Meetings</td>
<td>see description</td>
</tr>
<tr>
<td></td>
<td>Region 1: 317A</td>
<td>Region 2: 318B</td>
</tr>
<tr>
<td>8:00-8:30pm</td>
<td>Newly Elected RD/AD Orientation</td>
<td>Ballroom 313A-C</td>
</tr>
</tbody>
</table>

**Saturday, November 11**

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-7:30am</td>
<td>Delegate Credentialing</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>7:30-8:00am</td>
<td>Elections</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>8:00-10:30am</td>
<td>AMA-MSS General Assembly</td>
<td>Ballroom 313A-C</td>
</tr>
<tr>
<td>9:00am-12:00pm</td>
<td>National Service Project: Health Fair to Combat the Opioid Epidemic</td>
<td>University of Hawaii</td>
</tr>
<tr>
<td>9:00-10:00am</td>
<td>Being present: Physician wellness and mindfulness (Practice sustainability and satisfaction)</td>
<td>Room 320</td>
</tr>
<tr>
<td></td>
<td>Telemedicine: Improving patient care and health outcomes (Advocacy)</td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Situational leadership for physicians (Leadership)</td>
<td>Room 315</td>
</tr>
<tr>
<td>10:10-11:10am</td>
<td>Advocacy: Tools of the trade (Advocacy)</td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Generational changes: Managing up, leadership, and followership (Leadership)</td>
<td>Room 315</td>
</tr>
<tr>
<td></td>
<td>Trends in Academic Medicine: Community preceptors, innovations in pedagogy, and more (Practice sustainability and satisfaction)</td>
<td>Room 320</td>
</tr>
<tr>
<td>11:20am-12:20pm</td>
<td>Advocacy: What roles exist for physicians? (Advocacy)</td>
<td>Room 310</td>
</tr>
<tr>
<td></td>
<td>Achieving health equity through organized medicine as physician leaders (Leadership)</td>
<td>Room 315</td>
</tr>
<tr>
<td></td>
<td>Outside of the box: Physician innovators and entrepreneurs (Practice sustainability and satisfaction)</td>
<td>Room 320</td>
</tr>
</tbody>
</table>
2017 AMA Research Symposium

SCHEDULE OF EVENTS

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3 p.m.</td>
<td>Participant check-in/poster set up</td>
<td>Level 1: Kamehameha (Exhibit Hall III)</td>
</tr>
<tr>
<td>2–3 p.m.</td>
<td>Education session</td>
<td>Level 3: Room 311 (RFS Ballroom)</td>
</tr>
<tr>
<td>3–3:30 p.m.</td>
<td>Podium presenter set up</td>
<td>Level 3: Rooms 318A, 318B and 319A</td>
</tr>
<tr>
<td>3–4 p.m.</td>
<td>Poster judge check-in</td>
<td>Level 1: Kamehameha (Exhibit Hall III)</td>
</tr>
<tr>
<td>3–4 p.m.</td>
<td>Podium judge check-in</td>
<td>Level 3: Rooms 318A, 318B and 319A</td>
</tr>
<tr>
<td>4–5 p.m.</td>
<td>Podium presentations and judging</td>
<td>Level 3: Room 318A</td>
</tr>
<tr>
<td></td>
<td>AMA Medical Student Section podium</td>
<td>Level 3: Room 318B</td>
</tr>
<tr>
<td></td>
<td>AMA Resident and Fellow Section podium</td>
<td>Level 3: Room 319A</td>
</tr>
<tr>
<td></td>
<td>AMA International Medical Graduates Section podium</td>
<td>Level 3: Room 319A</td>
</tr>
<tr>
<td>4–6 p.m.</td>
<td>Poster presentations and judging</td>
<td>Level 1: Kamehameha (Exhibit Hall III)</td>
</tr>
<tr>
<td>4–6 p.m.</td>
<td>Meet and greet</td>
<td>Edward H. Livingston, MD, FACS, AGAF, Deputy Editor for Clinical Reviews and Education, <em>JAMA</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1: Kamehameha (Exhibit Hall III)</td>
</tr>
</tbody>
</table>

Agenda is subject to change.
## 2017 AMA House of Delegates Interim Meeting
Hawaii Convention Center & Hilton Hawaiian Village
Honolulu, Hawaii
November 11-14

### House of Delegates Agenda

#### Saturday, November 11

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00-6:00pm</td>
<td><strong>AMA House of Delegates Opening Session</strong>&lt;br&gt;Ceremonial - Speeches, Awards Presentations; Business - Rules of Order</td>
<td>TBA</td>
</tr>
<tr>
<td>6:00-8:00pm</td>
<td><strong>AMA-MSS Caucus</strong></td>
<td>320</td>
</tr>
</tbody>
</table>

#### Sunday, November 12

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:30am</td>
<td><strong>AMA House of Delegates Second Opening Session</strong>&lt;br&gt;Business - Introduction of Reports and Resolutions, Extraction of Information Reports, Supplementary Report of the Committee on Rules &amp; Credentials</td>
<td>TBA</td>
</tr>
<tr>
<td>8:30am-12:00pm</td>
<td><strong>AMA Reference Committee Hearings</strong></td>
<td>TBA</td>
</tr>
<tr>
<td>5:00-7:00pm</td>
<td><strong>AMA-MSS Caucus</strong></td>
<td>313C</td>
</tr>
</tbody>
</table>

#### Monday, November 13

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30-11:00am</td>
<td><strong>Joint AMA-MSS / RFS / YPS Caucus</strong></td>
<td>311</td>
</tr>
<tr>
<td>2:00-6:00pm</td>
<td><strong>AMA House of Delegates Business Section</strong></td>
<td>TBA</td>
</tr>
<tr>
<td>6:00-7:30pm</td>
<td><strong>AMA-MSS Caucus</strong></td>
<td>310</td>
</tr>
</tbody>
</table>

#### Tuesday, November 14

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:45am-12:00pm</td>
<td><strong>AMA House of Delegates Business Section</strong></td>
<td>TBA</td>
</tr>
</tbody>
</table>
2017 AMA Medical Student Section Interim Meeting
Hawaii Convention Center
Honolulu, Hawaii
November 9-11

Descriptions of education programs

Thursday, November 9

Advocacy Workshop: The Opioid Epidemic
AMA-MSS Committee on Legislation & Advocacy
3:00–4:00pm | Ballroom 313 A-C

Guest speakers: William Estes, Government Relations Advocacy Fellow, AMA | Joy Lee, Member, AMA Council on Constitution and Bylaws

Surviving an Epidemic: The Opioid Crisis of Today and Tomorrow
AMA-MSS Committee on Legislation & Advocacy and AMA-MSS Committee on Community Service
4:00–5:30pm | Ballroom 313 A-C
The Committee on Legislation and Advocacy is pleased to host Dr. Scott Miscovich, family physician and chairman of the Hawaii Opioid and Overdose Leadership Action Work Group, in an interactive discussion of the many factors that coalesced to precipitate the opioid crisis of today and of the work being performed by various stakeholders laying the foundation for a more hopeful future. Following this discussion, the National Community Service Committee along with the Region Community Service Chairs will present an educational session intended to teach students how to host a community service event combatting the opioid epidemic in their own community. By teaching about the process and how to overcome barriers to hosting an event, we can help our MSS take the national service project truly national.

Guest speaker: Scott Miscovich, MD, Family Physician; Chairman, Hawaii Opioid Overdose Leadership Action Workgroup (HO’OLA)

Welcome to Interim 2017: Orientation
AMA-MSS Governing Council
5:30–7:00pm | Ballroom 313 A-C
Learn about everything the AMA Medical Student Section Interim Meeting has to offer! Hear from your AMA Medical Student Section (AMA-MSS) Governing Council about how to get the most out of your national AMA medical student conference and learn about additional leadership opportunities within our Section.

Presenters: Anna Yap, AMA-MSS Speaker & Jay Llaniguez, MS, AMA-MSS Vice Speaker
Delegate Credentialing
7:00–7:30am | Ballroom 313 A-C
Registered delegates must pick up their voting badges at the back of the Ballroom.

Candidate Forum
7:30–8:00am | Ballroom 313 A-C
Take an opportunity to interact with the medical student candidates running for your 2017-2018 AMA-MSS Governing Council Chair-Elect and AMA Board of Trustees - Student Member.

LGBTQI+ Research: What Do We Know and What Don’t We Know?
AMA-MSS Committee on LGBTQ Issues
8:00–9:00am | Room 310
Sexual and gender minorities (i.e. lesbian, gay, bisexual, transgender, and queer individuals and communities) face significant health disparities. However, research remains limited. Dr. Streed, immediate past chair of the AMA Committee on LGBTQ Issues, is an internal medicine physician that has worked for more than a decade advocating for the health and well-being of lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals and communities. Come hear Dr. Streed provides an overview of past and present research and where we need to explore next.

Guest speaker: Carl G. Streed Jr., MD, Immediate Past Chair, Advisory Committee on LGBTQ Issues, AMA; Fellow, Division of General Internal Medicine & Primary Care, Brigham & Women's Hospital

Recommendations for treating transgender patients
AMA-MSS Committee on LGBTQ Issues
9:00–10:00am | Room 310
Guest speaker: Erick Eiting, MD, MPH, MMM, Young Physicians Section Representative, Advisory Committee on LGBTQ Issues, AMA Director of Emergency Medicine, Mount Sinai Beth Israel; Director of Population Health, New York City Health + Hospitals, Division of Correctional Health Services

Rights: What Are They And Who Ensures They Are Protected?
AMA-MSS Committee on LGBTQ Issues and AMA-MSS Committee on Bioethics and Humanities
10:00–11:00am | Room 310
A great deal of controversy centers around the concept of healthcare as a right, but we often forget to pose the question “What exactly is a right?” Join us at this discussion-style session where we examine rights and discuss who protects them and our role in ensuring them as physician-advocates.

Guest speaker: Frank Clark, MD, FAPA, Chair, AMA Minority Affairs Section (MAS); Geriatric Psychiatrist; Adjunct Assistant Professor of Psychiatry and Behavioral Medicine, Virginia Tech Carilion School of Medicine

Delegate Credentialing
12:00–12:30pm | Ballroom 313 A-C
Registered delegates must pick up their voting badges at the back of the Ballroom.

Social Determinants of Health: Native Hawaiians
AMA-MSS Committee on Minority Issues and AMA-MSS Committee on Medical Education
1:00pm–2:00pm | Room 310
Hawaii State Senator Josh Green, MD will be joining us to share his experiences as both a politician and physician dedicated to improving health of his community. Since 2008, Josh has served in the Hawaii State Senate, where as Chair of the Health Committee and current Chair of the Human Services Committee he has worked to pass new laws that strengthen and support Hawaii families. He will lead us in a discussion on traditional Hawaiian health care practices along with the social determinants of health of Native Hawaiians.

Guest speaker: Josh Green, MD, Senator, District 3, Hawaii State Senate, Hawaii State Capitol

15th Annual AMA Research Symposium
Co-hosted by AMA Medical Student Section (AMA-MSS), AMA Resident and Fellow Section (AMA-RFS), and AMA International Medical Graduates Section (AMA-IMG)
1:00-3:00pm Participant check-in/poster set up
2:00-3:00pm Education session, Edward Livingston, MD, FACS, AGAF, Deputy Editor, JAMA
3:00-3:30pm Podium presenter set up
4:00-5:00pm Podium presentations
4:00-6:00pm Poster presentations
4:00-6:00pm Meet and Greet with Edward Livingston, MD, FACS, AGAF, Deputy Editor, JAMA
Take the opportunity to view the original research of medical students, residents, and international medical graduates. All meeting attendees and physicians in the local area are invited. Research Symposium participants see great value in networking with practicing physicians and AMA leadership. Dr. Livingston will be available to meet researchers and answer their questions about the publishing process in the AMA Research Symposium exhibition hall.

Exploring Implicit Bias & Its Implications in Health Care
AMA-MSS Committee on Minority Issues
2:00–3:00pm | Room 310
Joining us will be Justin Levinson, JD, a leading implicit bias researcher, to discuss implicit bias in healthcare. A Professor of Law at the University of Hawai‘i Manoa, Mr. Levinson has been a lead researcher in the field on implicit bias. Although most of this work focuses on implicit bias in the criminal justice system, his expertise can easily be applied to the general explanation of implicit bias and how it applies in other fields. Mr. Levinson will also lead us in thought-provoking exercises to facilitate better understanding of how implicit bias affects our own lives and future careers as physicians.

Guest speaker: Justin D. Levinson, JD, Professor of Law, University of Hawai‘i at Mānoa, William S. Richardson School of Law

Healthcare’s hidden victims: Addressing sex trafficking in our communities
AMA-MSS Committee on Global and Public Health
3:00–4:00pm | Room 310
This event intends to educate medical students about research and patient care strategies regarding the current sex trafficking crisis in national and global communities. The Committee for Global and Public Health (CGPH) hopes to begin the dialogue that equips students with skills necessary to increase the identification of at risk and vulnerable patients. We hope to present an avenue for increased AMA advocacy for patients faced with abuse and forced prostitution.

Guest speaker: TBA

International Comparative Health Systems
AMA-MSS Committee on Economics and Quality in Medicine
4:00–5:00pm | Room 310
As significant portions of the US health care system change, the health care systems in other countries around the world become increasingly important to study. However, as a whole, there is a gap in the conversation
around the comparative performance of the US against that of others. The goal of this program is to present brief, relevant analyses of several other health systems in the world, and both the pitfalls to be avoided, and the lessons to be learned.

**Team-based Communication in Healthcare 101**  
*AMA-MSS Committee on Long Range Planning*  
5:00–6:00pm | Room 310  
Effective team communication is vital for the care of our future patients. In this hands-on session, you will practice your communication skills in small groups through a fun team-building activity. Dr. Glenn Loomis, Chair of AMA Council on Long Range Planning & Development (CLRPD), will provide personal lessons from his experience overseeing a health care system in order to improve your communication within a team.

Guest speaker: Glenn Loomis, MD, Chair, AMA Council on Long Range Planning & Development

---

**Saturday, June 10**

**Delegate Credentialing**  
7:00–7:30am | Ballroom 313 A-C  
Registered delegates must pick up their voting badges at the back of the Ballroom.

**Elections**  
7:30–8:00am | Ballroom 313 A-C  
Election voting opens promptly at 7:30am and will close sharply at 8:00am.

**Being present: Physician wellness and mindfulness**  
9:00–10:00am | Room 320 | “Practice sustainability and satisfaction”  
Physicians are faced with numerous stressors including increasing administrative responsibilities, regulatory pressures and evolving payment and care delivery models. Professional pressures and stress can lead to physician burnout, which can have an impact on organizational productivity, morale, costs and the quality of care being delivered. This session will provide you with an overview of contributing factors associated with physician burnout and ways you can address burnout individually and organizationally.

**Telemedicine: Improving patient care and health outcomes**  
9:00–10:00am | Room 310 | “Advocacy”  
Telemedicine technology has the potential to transform health care delivery and address many care coordination challenges facing the U.S. health care system. It can facilitate remote, mobile and site-to-site medical care. Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality and when properly used has the potential to reduce the rate of growth in health care spending. Implementing telemedicine in your practice can expand access to care, provide a better patient experience and improve health outcomes when implemented properly.

**Situational leadership for physicians**  
9:00–10:00am | Room 315 | “Leadership”  
As leaders in your hospital, medical school, or practice, you need to understand when, and how, to adjust your leadership style to fit the needs of your staff and to ensure improved patient care and quality outcomes. Join expert faculty for this session to help you develop the required skills to adjust your leadership style, based on the specific situation, including the number and type of health professionals and the needs of the patient.

**Advocacy: Tools of the trade**  
10:10–11:10am | Room 310 | “Advocacy”
Physician advocates play a vital role in influencing policymakers on matters that affect patient care and outcomes. Despite the importance of such advocacy, physicians rarely receive formal training on how to conduct advocacy activities to achieve goals for their patients and the profession. This program will introduce tools and skills that every physician should employ when connecting with decision makers, including how to organize your peers, how to build relationships with legislators, and how to effectively communicate an advocacy message.

**Generational changes: Managing up, leadership, and followership**
10:10–11:10am | Room 315 | “Leadership”
Organized medicine, health care systems, and physician groups have evolved and are designed with the current workforce in mind. In contrast, younger generations are increasingly diverse and have different expectations than their predecessors with regard to work-life balance, lines of authority, technology, privacy, and social media. Current systems are not prepared for what these differences will produce with regards to the future workforce, work environment and patient outcomes. You will learn techniques to help you work more effectively with colleagues from multiple generations.

**Trends in Academic Medicine: Community preceptors, innovations in pedagogy, and more**
10:10–11:10am | Room 320 | “Practice sustainability and satisfaction”
How can you mentor the future generation of physicians? For community-based practicing physicians, serving as a preceptor to medical student and/or resident/fellow trainees is an excellent way to do just that. Learn more about precepting and how to balance it with clinical and administrative duties. Both the administrative perspective (i.e., what schools can offer, trends in funding, faculty appointments, etc.) as well as the preceptor viewpoint will be addressed in this session.
Another key trend in medical education is the information explosion and the need for future physicians to move beyond mere memorization to develop critical thinking and problem-solving skills. Learn about the many ongoing innovations in medical education (including those of the AMA’s Accelerating Change in Medical Education consortium) that can help make learning more readily applicable and relevant to future physicians. Also, be sure to bring your own ideas to share during the open forum segment of this session.

**Advocacy: What roles exist for physicians?**
11:20am–12:20pm | Room 310 | “Advocacy”
Physicians have an important role to play in health care advocacy. With health care accounting for a large share of the American economy and the current evolutionary state of medicine, physicians are in a prime position to help navigate and influence these discussions. This program will highlight the experiences of a group of physicians who advocate for their patients and the profession in diverse ways, including a physician legislator and a physician leader of a health system with its own lobbying arm. Join us for a discussion about how you can take an active role in advocacy and the political process.

**Achieving health equity through organized medicine as physician leaders**
11:20am–12:20pm | Room 315 | “Leadership”
The implementation of the ACA has closed the gap but disparities in care and health outcomes continue to persist. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health care on the basis of their race, ethnicity, gender, gender identity, socioeconomic status, and sexual orientation. It has been noted that a comprehensive, multilevel strategy is needed to eliminate these disparities. After participating in this session, you will learn about how you can integrate effective interventions, new techniques and patient considerations in order to mitigate and eliminate health disparities.

**Outside of the box: Physician innovators and entrepreneurs**
11:20am–12:20pm | Room 320 | “Practice sustainability and satisfaction”
As a physician, you can shape the future of health care. Through lending your expertise to a tech company or pursuing a career as an entrepreneur, you have options to make a lasting impression on the future of medicine. Join fellow physician-entrepreneurs for a discussion about how you can lend your expertise to influence health care and shape the future of medicine.
Educational sessions: Sponsored by AMA sections
2017 AMA Interim Meeting • Hawai‘i Convention Center, Honolulu

The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™, unless otherwise noted. The deadline to claim credit is Dec. 31, 2017.

**Being present: Physician wellness and mindfulness**
9–10 a.m. Saturday, Nov. 11, Room 320
Physicians are faced with numerous stressors including increasing administrative responsibilities, regulatory pressures and evolving payment and care delivery models. Professional pressures and stress can lead to physician burnout, which can have an impact on organizational productivity, morale, costs and the quality of care being delivered. This session will provide you with an overview of contributing factors associated with physician burnout and ways you can address burnout individually and organizationally.

*Track: Practice Sustainability and Satisfaction*

**Telemedicine: Improving patient care and health outcomes**
9–10 a.m. Saturday, Nov. 11, Room 310
Telemedicine technology has the potential to transform health care delivery and address many care coordination challenges facing the U.S. health care system. It can facilitate remote, mobile and site-to-site medical care. Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality and when properly used has the potential to reduce the rate of growth in health care spending. Implementing telemedicine in your practice can expand access to care, provide a better patient experience and improve health outcomes when implemented properly.

*Track: Advocacy*

**Situational leadership for physicians**
9–10 a.m. Saturday, Nov. 11, Room 315
As leaders in your hospital, medical school or practice, you need to understand when, and how, to adjust your leadership style to fit the needs of your staff and to ensure improved patient care and quality outcomes. Join expert faculty for this session to help you develop the required skills to adjust your leadership style, based on the specific situation, including the number and type of health professionals and the needs of the patient.

*Track: Leadership*

**Advocacy: Tools of the trade**
10:10–11:10 a.m. Saturday, Nov. 11, Room 310
Physician advocates play a vital role in influencing policymakers on matters that affect patient care and outcomes. Despite the importance of such advocacy, physicians rarely receive formal training on how to conduct advocacy activities to achieve goals for their patients and the profession.

This program will introduce tools and skills that every physician should employ when connecting with decision makers, including how to organize your peers, how to build relationships with legislators, and how to effectively communicate an advocacy message.

*Track: Advocacy*
Generational changes: Managing up, leadership and followership
10:10–11:10 a.m. Saturday, Nov. 11, Room 315
Organized medicine, health care systems, and physician groups have evolved and are designed with the current workforce in mind. In contrast, younger generations are increasingly diverse and have different expectations than their predecessors with regard to work-life balance, lines of authority, technology, privacy, and social media. Current systems are not prepared for what these differences will produce with regards to the future workforce, work environment and patient outcomes. You will learn techniques to help you work more effectively with colleagues from multiple generations.

Track: Leadership

Trends in Academic Medicine: Community preceptors, innovations in pedagogy, and more
10:10–11:10 a.m. Saturday, Nov. 11, Room 320
How can you mentor the future generation of physicians? For community-based practicing physicians, serving as a preceptor to medical student and/or resident/fellow trainees is an excellent way to do just that. Learn more about precepting, and how to balance it with clinical and administrative duties. Both the administrative perspective (i.e., what schools can offer, trends in funding, faculty appointments, etc.) as well as the preceptor viewpoint will be addressed in this session.

Another key trend in medical education is the information explosion and the need for future physicians to move beyond mere memorization to develop critical thinking and problem-solving skills. Learn about the many ongoing innovations in medical education (including those of the AMA’s Accelerating Change in Medical Education consortium) that can help make learning more readily applicable and relevant to future physicians. Also, be sure to bring your own ideas to share during the open forum segment of this session.

Track: Practice Sustainability and Satisfaction

Advocacy: What roles exist for physicians?
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 310
Physicians have an important role to play in health care advocacy. With health care accounting for a large share of the American economy and the current evolutionary state of medicine, physicians are in a prime position to help navigate and influence these discussions.

This program will highlight the experiences of a group of physicians who advocate for their patients and the profession in diverse ways, including a physician legislator and a physician leader of a health system with its own lobbying arm. Join us for a discussion about how you can take an active role in advocacy and the political process.

Track: Advocacy

Achieving health equity through organized medicine as physician leaders
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 315
The implementation of the ACA has closed the gap but disparities in care and health outcomes continue to persist. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health care on the basis of their race, ethnicity, gender, gender identity, socio-economic status, and sexual orientation. It has been noted that a comprehensive, multilevel strategy is needed to eliminate these disparities. After participating in this session, you will learn about how you can integrate effective interventions, new techniques and patient considerations in order to mitigate and eliminate health disparities.

Track: Leadership

Outside of the box: Physician innovators and entrepreneurs
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 320
As a physician, you can shape the future of health care. Through lending your expertise to a tech company or pursuing a career as an entrepreneur, you have options to make a lasting impression on the future of medicine. Join fellow physician-entrepreneurs for a discussion about how you can lend your expertise to influence health care and shape the future of medicine.

Track: Practice Sustainability and Satisfaction
2017 AMA Medical Student Section Interim Meeting

Hawaii Convention Center
Honolulu, Hawaii
November 9-11

Convention Committees

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

Trevor Cline, Chair
University of California Davis School of Medicine

Dan Pfeifle, Chair
University of South Dakota SOM Sioux Falls

Theodore Rader, Vice Chair
University of Toledo College of Medicine

Kevin Stephenoff, Vice Chair
University of Toledo College of Medicine

Daniel Kim
Pennsylvania State University College of Medicine

Usman Aslam
New York Institute of Technology College of Osteopathic Medicine

Brianna Manes
University of California Riverside School of Medicine

Sarah Armenia
Rutgers New Jersey Medical School

Maren Loe
Washington University School of Medicine in St. Louis

Zachary Appelbaum
University of Miami Leonard M. Miller School of Medicine

Emal Lesha
Tufts University School of Medicine

Lauren Engel
Medical College of Wisconsin

Angela Wu
University of Arizona College of Medicine

Sinan Ali Bana
Texas A&M University COM

Christopher Androski
University of Massachusetts Medical School

Amber Gautam
Brody SOM at East Carolina University

Ali Bokhari
New York Institute of Technology College of Osteopathic Medicine

Reference Committee
GC Liaisons: Anna Yap, MSS Speaker & Jay Llaniquez, MSS Vice Speaker

Rachel Ekaireb, Chair
University of California San Francisco SOM

Benjamin Bush
University of South Alabama College of Medicine

J. Steven Ekman
Washington University School of Medicine in St. Louis

Hari Iyer
Northeast Ohio Medical University

Aleesha Shaik
Drexel University College of Medicine

Kevin Qin, Chair
University of Toledo College of Medicine

Celeste Peay
Boston University SOM

Ajeet Singh
Loyola University Chicago Stritch School of Medicine

Brianna Whitborn
Campbell University School of Osteopathic Medicine

Robbie Good
University of Texas Medical Branch School of Medicine
Convention Committees (continued)

**Rules Committee**
GC Liaisons: Helene Nepomuceno, MSS Chair, Anna Yap, MSS Speaker & Jay Llaniguez, MSS Vice Speaker

Halea Meese, Chair
Jordan Rimes
Arvind Haran
Daniel Kim
Usman Aslam

Club Liaisons:
Helene Nepomuceno, MSS Chair
Anna Yap, MSS Speaker
Jay Llaniguez, MSS Vice Speaker

University of Colorado SOM
University of Mississippi SOM
Indiana University SOM Indianapolis
Pennsylvania State University COM
New York College of Osteopathic Medicine

**Community Service Committee**
GC Liaisons: Kelly Landeen, MSS At-Large Officer, Jay Llaniguez, MSS Vice Speaker & Anna Yap, MSS Speaker

Jaswanth Raj Kintada, Chair
Declan Grabb
Denise Powell
Laura Newton
Rouzbeh Kotaki
Stella Szeto

University of Texas Health Science Center at San Antonio
University of Colorado SOM
University of Mississippi SOM
University of Nebraska COM
University of Texas Rio Grande Valley School of Medicine
Boston University School of Medicine

**Hospitality Committee**
GC Liaisons: Kelly Landeen, MSS At-Large Officer, Anna Yap, MSS Speaker & Jay Llaniguez, MSS Vice Speaker

Hillary Landau, Chair
Avani Patel
Eric Lakey
Lauren Forbes

Tufts University School of Medicine
University of Mississippi SOM
University of Colorado SOM
Brody SOM at East Carolina University

**Credentials Committee**
GC Liaisons: Anna Yap, MSS Speaker, Jay Llaniguez, MSS Vice Speaker & Helene Nepomuceno, MSS Chair

Nabil Saleem, Chair
Margaret Teets
Richard Trevino
Gillian Naro
Sinan Ali Bana
Christopher Androski
Amber Gautam

Maine Medical Center
University of Colorado SOM
University of Texas Health Science Center at San Antonio
Pennsylvania State University COM
Texas A & M University COM College Station
University of Massachusetts Medical School
Brody SOM at East Carolina University

**Logistics Committee**
GC Liaisons: Anna Yap, MSS Speaker, Jay Llaniguez, MSS Vice Speaker & Karen Dionesotes, MSS Vice Chair

Vartan Pahalyants, Chair
Anneliese Vitha
Abra Shen
Angela Chang
Jonathan Gevorkian
Pauline Huynh
Maren Loe

Harvard Medical School
University of Miami Miller SOM
Harvard Medical School
University of Miami Miller SOM
University of Nevada Reno School of Medicine
Johns Hopkins University School of Medicine
Washington University in St. Louis
Convention Committees (continued)

Parliamentary Procedure Committee
GC Liaisons: Anna Yap, MSS Speaker, Jay Llaniguez, MSS Vice Speaker & Karen Dionesotes, MSS Vice Chair

Kshma Kulkarni, Chair Touro University College of Osteopathic Medicine
Andrew Vallejo Boston University SOM
Benjamin Chadek-Feeley Oklahoma State University College of Osteopathic Medicine
Maximilian Pany Harvard Med School
Brianna Manes University of California Riverside SOM
Sarah Armenia Rutgers New Jersey Medical School (Newark)
# I-17 SEATING CHART

I-17 Seating Chart is color coded by region

<table>
<thead>
<tr>
<th>PLATFORM</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>NE 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MO 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WI 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IA 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MO 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MN 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KY 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OH 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IN 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WV 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DC 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NJ 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DC2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VT 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RI 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PIMA/NMSS/NMSO
### BASIC RULES GOVERNING MOTIONS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIVILEGED MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>SUBSIDIARY MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Main motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Limit or extend debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Debatable motions</td>
<td>Amend, close debate</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes</td>
<td>Majority</td>
<td>Reformable motions</td>
<td>Amend, close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td><strong>MAIN MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. (a) The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>(b) Specific main motions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopt in-lieu-of</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Referred motion</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Recall from committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Vote on main motion</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes⁴</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Adopted main motion</td>
<td>Close debate, limit debate</td>
<td>Yes⁴</td>
</tr>
<tr>
<td>Resind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Adopted main motion</td>
<td>Subsidiary, except amend</td>
<td>No</td>
</tr>
</tbody>
</table>

### INCIDENTAL MOTIONS

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

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

2. Restricted.

3. Is not debatable when applied to an undebatable motion.

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

5. Withdraw may be applied to all motions.

6. Renewable at the discretion of the presiding officer.

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

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

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

These comments were reviewed by the Reference Committee to create the final Reference Committee Report, which will be made available on Friday, November 3, one week in advance of the MSS Assembly Meeting. The final report and its recommendations will serve as the basis for extraction, discussion, and voting at the onsite Assembly Meeting on Friday, November 10 at 8:00 AM.
Whereas, The Health Insurance Portability and Accountability Act (HIPAA) instituted data privacy and security protocols for patient health information; and

Whereas, HIPAA’s Privacy Rule places “limitations on the sale of medical information to third parties for marketing purposes” and prevents medical information from being disclosed unless permitted or required; and

Whereas, Secondary use of health data consists of using protected health information (PHI) outside of direct healthcare delivery including analysis, research, quality/safety measurement, public health, payment, provider certification and accreditation, marketing, and other business applications, including strictly commercial activities; and

Whereas, Under HIPAA, patient consent may be requested but is not required to use and disclose PHI for treatment, payment, and healthcare operations (TPO) whereas patient authorization is required where “voluntary consent is not sufficient to permit a use or disclosure of protected health information” which largely consists of any use outside of TPO, unless an exception applies; and

Whereas, HIPAA does not apply after data is de-identified nor does it prohibit selling or sharing of de-identified data without prior patient authorization for “research, public health, law enforcement, judicial proceedings, and other ‘public interest and benefit activities’”; and

Whereas, The extent to which patient data collection and use for purposes not directly related to patient care and public health such as for pure commercial intent is not well understood or regulated; and

Whereas, A multimillion-dollar industry has steadily been established based on sales of patient health-related information; and

Whereas, In US courts, transactions involving de-identified patient data irrespective of their purpose have come to be labeled as expressions of free speech; and

Whereas, The issue of who retains ownership over PHI whether it be the patient, provider, government or another entity is highly debated and has yet to be formally settled; and
Whereas, Done voluntarily or not, as individuals continue to divulge increasingly personal
information in areas outside of healthcare, it becomes easier to consolidate the information and
identify those individuals in aggregated pools of anonymized health data;¹ ³,⁶,¹⁴,¹⁵ and

Whereas, The information patients reveal for their treatment often pertain to very personal and
sensitive areas of their lives, and it is vulnerability generated by pain, distress, and fear about
their well-being that behooves them to disclose intimate information to providers;⁶ and

Whereas, AMA policy H-315.983 states that only de-identified and/or aggregate data should be
used for “business decisions,” including sales, mergers, and similar business transactions when
ownership or control of medical records changes hands; and

Whereas, AMA Code of Ethics Section 3.2.4 Paragraph 2 states “Information gathered and
recorded in association with the care of a patient is confidential. Patients are entitled to expect
that the sensitive personal information they divulge will be used solely to enable their physician
to most effectively provide needed services. Disclosing information to third parties for
commercial purposes without consent undermines trust, violates principles of informed consent
and confidentiality, and may harm the integrity of the patient-physician relationship”;¹⁶ and

Whereas, Section 3.2.4 Paragraph 3 (a) enables the release of patient information so long as it
is de-identified and, together with paragraph 3 (b), only asks that patients be informed of the
impending release without providing patients means to prevent third parties from utilizing in any
form for commercial purposes the “sensitive personal information” they divulged for care; and

Whereas, Section 3.2.4 as currently written above is internally conflicting as it emphasizes
patient consent in Paragraph 2 while Paragraph 3 immediately defers to patients only needing
to be informed about use of their de-identified information rather than providing consent; and

Whereas, Section 3.2.4 Paragraph 4 (c) may conflict with HIPAA in that patient authorization
rather than consent is sometimes mandated for release of identifiable patient information to third
parties for reasons other than TPO; and

Whereas, A lack of accountability and transparency on how a patient’s own health data will be
used beyond their immediate care undermines both the informed consent process and the
patient-physician relationship, and impairs future efforts in healthcare, research, and public
health,⁶,¹⁶,¹⁷ therefore be it

RESOLVED, That our AMA refer for study Section 3.2.4 of the Code of Ethics to establish
patient consent for de-identified patient information and report findings and recommendations
back to the AMA House of Delegates.

Fiscal Notes: Minimal, 6

Date Received: 9/20/17

References

Information Privacy. https://www.hhs.gov/hipaa/for-professionals/security/laws-
regulations/index.html. Published 2013.
2. Goldstein MM, Pewen WF. The HIPAA Omnibus Rule: implications for public health


5. Cornell Law Legal Information Institute. 45 CFR 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required. https://www.law.cornell.edu/cfr/text/45/164.512%0D. Published 2016.


Relevant AMA and AMA-MSS policy:

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
(a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for “business decisions,” including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

Police, Payer, and Government Access to Patient Health Information H-315.975
(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.
(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.
(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.
(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws.

(1) Our AMA urges the Federal Government to consider augmenting the standards of the Common Rule to state that IRBs may waive or modify the requirement of a researcher to obtain the specific informed consent of a research subject for use of his or her personally identifiable health information only when it can be documented that:
(a) There is no practicable alternative to the use of such personally identifiable health information and that, in any case, such information is de-identified at the earliest practicable opportunity;
(b) The health researcher has fully disclosed which of the personally identifiable health information to be collected or created will be linked to other personally identifiable health information;
(c) If, in the course of the proposed research, such health researcher intends to link personally identifiable health information to other health information or if there is a risk that such information may be linked, appropriate safeguards are employed to protect such information against re-identification or subsequent unauthorized linkage;
(d) The institutional review board shall have the opportunity to review any publication of information based upon the personally identifiable health information collected or created under
the provisions of this section to ensure that no disclosures are made which might identify an individual;
(e) At the conclusion of the proposed health research or at some specific date, the health researcher shall destroy all of the data containing personally identifiable health information as well as all copies of such data, but that the institutional review board may extend the date of destruction if the researcher demonstrates a continuing or new need for protected health information for which such researcher would be qualified for a waiver of informed consent in accordance with this section;
(f) The health researcher has presented adequate assurances that none of the data containing protected health information will be given, loaned, sold, disseminated or otherwise disclosed to other parties.

(2) Our AMA encourages medical schools, teaching institutions, and other entities that conduct medical research to assure that their IRBs are afforded adequate personnel and other resources to accomplish their mission "to safeguard the rights and welfare of human research subjects."

Work of the Task Force on the Release of Physician Data H-406.990
Release of Claims and Payment Data from Governmental Programs
The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.

Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.

Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:
1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare
and/or Medicaid claims data, or allows the use of such data to construct profiles of identified
physicians or physician practices. Such disclosures must meet the following criteria:
(a) the publication or release of this information is deemed imperative to safeguard the public
welfare;
(b) the raw data regarding physician claims from governmental healthcare programs is:
(i) published in conjunction with appropriate disclosures and/or explanatory statements as to the
limitations of the data that raise the potential for specific misinterpretation of such data. These
statements should include disclosure or explanation of factors that influence the provision of
care including geographic location, specialty, patient mix and demographics, health plan design,
patient compliance, drug and supply costs, hospital and service costs, professional liability
coverage, support staff and other practice costs as well as the potential for mistakes and errors
in the data or its attribution, in addition to other relevant factors.
(ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or
inaccurate physician-specific medical practice data.
(c) any physician profiling which draws upon this raw data acknowledges that the data set is not
representative of the physicians' entire patient population and uses a methodology that ensures
the following:
(i) the data are used to profile physicians based on quality of care provided - never on utilization
of resources alone - and the degree to which profiling is based on utilization of resources is
clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians
across appropriate specialties, such as the AMA-convened Physician Consortium for
Performance Improvement.
(iii) the data and methodologies used in profiling physicians, including the use of representative
and statistically valid sample sizes, statistically valid risk-adjustment methodologies and
statistically valid attribution rules produce verifiably accurate results that reflect the quality and
cost of care provided by the physicians.
(d) any governmental healthcare data shall be protected and shared with physicians before it is
released or used, to ensure that physicians are provided with an adequate and timely
opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to
individual physicians) and any physician profiling results derived from the analysis of physician-
specific medical practice data to ensure accuracy prior to their use, publication or release.
(BOT Rep. 18, A-09)

Guiding Principles, Collection and Warehousing of Electronic Medical Record
Information H-315.974
Our AMA expressly advocates for physician ownership of all claims data, transactional data and
de-identified aggregate data created, established and maintained by a physician practice,
regardless of how and where such data is stored but specifically including any such data
derived from a physician's medical records, electronic health records, or practice management
system, while preserving the principle that physicians act as trusted stewards of Protected
Health Information. (Res. 802, I-05), (Reaffirmed: BOT Rep. 19, I-06), (Reaffirmed: BOT Rep.
17, A-13)

315.001MSS Patient Confidentiality and Government Investigations
AMA-MSS opposes the implementation of federal legislation that would enable any government
agency or representative of such agency to access a patient’s medical records without the
patient’s knowledge and consent or court order. (MSS Amended Sub Res 11, I-97) (Reaffirmed:
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 2
(I-17)

Introduced by: Region 1; Region 2; Region 7; Lauren Engel, Medical College of Wisconsin; Moudi Hubeishy, SUNY Buffalo School of Medicine; Dan Pfeifle, University of South Dakota Sanford School of Medicine; Steven Eckman, Washington University School of Medicine in St. Louis; Fatima Mirza, Yale School of Medicine

Subject: Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, The MSS Governing Council maintains the authority to act on behalf of the MSS when the Assembly is not in session “in formulating decisions related to the development, administration, and implementation of student activities, programs, goals, and objectives,” including the ability to update the MSS Resolution Review Process as deemed necessary; and

Whereas, MSS Region Delegates and Alternate Delegates under the direction of the MSS Delegate and Alternate Delegate make up the MSS Caucus for the AMA House of Delegates (HOD) and contribute to determining the outcomes of MSS resolutions in the HOD through debate of resolutions within the MSS caucus, the development of strategy, and coordination with other groups within the House of Delegates; and

Whereas, The MSS Caucus takes positions on HOD resolutions according to MSS policy, and thereby is dependent upon the quality of resolutions being passed by the MSS to guide the actions of the MSS Regional Delegates and Alternate Delegates in the HOD; and

Whereas, Between Annual 2010 and Interim 2016, 116 AMA-MSS resolutions have passed through the AMA House of Delegates out of a total of 215; and

Whereas, Between Annual 2010 and Interim 2016, 253 AMA House of Delegates resolutions were referred, 32 of those being external AMA-MSS resolutions; and

Whereas, From the above data, 54% of AMA-MSS resolutions have passed in the AMA House of Delegates, and 15% of AMA-MSS resolutions have been referred, leaving the remaining 31% of AMA-MSS resolutions to be fated as “not adopted,” “reaffirmation,” or “substitute resolution adopted in lieu of the resolution; and

Whereas, After the update to the resolution review process for Annual 2016, no objective data has been collected on the impact of these changes; therefore be it

RESOLVED, That our AMA-MSS study the outcomes of MSS resolutions in the AMA House of Delegates and track this data at intervals deemed appropriate by the AMA-MSS Governing Council; and be it further
RESOLVED, That our AMA-MSS Governing Council under the direction of the Delegate and Alternate Delegate consider the results of the study to continue to improve and update the resolution review process.

Fiscal note: Minimal, 4

Date Received: 

References:


RELEVANT AMA AND AMA-MSS POLICY:

MSS Policy:

630.008MSS Referencing Data in Resolutions: It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information.

630.016MSS MSS Reference Committee Information: AMA-MSS and the Office of Medical Student Services will release to state delegation chairperson or resolution author, a copy of the AMA-MSS Reference Committee Packet upon such request upon arrival at the AMA-MSS meeting.

630.029MSS Changes in MSS Resolutions Forwarded to the AMA House of Delegates: It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House of Delegates (when they agree) may make grammatical or syntax changes in MSS resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution.

630.037MSS Reaffirmation Calendar: AMA-MSS will implement and use a reaffirmation consent AMA-MSS Digest of Policy Actions/125 calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy.

630.055MSS Implementation of MSS Policy: AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current, especially focusing on action called for by external policies.

630.072MSS Policy-Making Procedures: The MSS Governing Council will create a task force to evaluate the pilot approach proposed for I-12, and research the policy-making procedures of the MSS Assembly, with clarification to the Internal Operating Procedures as appropriate, and recommend a process for future implementation to ensure proper and efficient consideration of the items of business of the MSS Assembly.

630.074MSS Review of AMA-MSS Statements of Support of HOD Policies: (1) The formally-supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support.

645.031MSS Policy-making Procedures: (1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list of
all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. (3) That Reference Committees be encouraged to recommend GC Action Items in future report reasoning. (4) The MSS Internal Operating Procedures will be amended in order to eliminate the advocacy-only rule. (5) All authored resolutions are submitted to the region of the resolution’s primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution’s author to offer feedback and suggestions prior to the MSS final resolution deadline. (6) The MSS Internal Operating Procedures will be revised to require resolutions to be submitted 50 days prior to the start of an Annual or Interim Meeting. (7) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author’s school is not located, with each resolution’s average ranking subsequently being released to the author. (8) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established deadlines. (9) That the MSS Internal Operating Procedures be revised to require that all resolutions recommended for reaffirmation by the MSS Reference Committee will require 1/3 of all present delegates to vote for its extraction from the Final Reference Committee report.

645.032MSS Continued Support for the Virtual Reference Committee: AMA-MSS supports the continued implementation and utilization of the Virtual Reference Committee, including the use of online testimony to develop a Reference Committee report prior to each AMA and AMA-MSS national meeting.

AMA Policy:
Procedure, B-2.11
2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization’s house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.
2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates at any time before the close of business on the day preceding the final day of the meeting.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business of the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting.

2.11.3.3 Reports of Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time before the close of business on the day preceding the final day of a meeting.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.5 New Business on Final Day of House of Delegates Meeting.

2.11.5.1 Requirements. Reports, recommendations, resolutions or other new business presented by the Board of Trustees on the final day of a meeting shall be accepted as business before the House and shall not be referred to a reference committee, but adoption of the recommendation(s) in the report or other item(s) of business shall require a three-fourths vote of delegates present and voting.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

Guidelines for Drafting a Resolution or Report G-600.061
Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:

(1) When proposing new AMA policy or modification of existing policy, the resolution should meet the following criteria:
(a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;

(b) The proposed policy should be clearly identified at the end of the resolution;

(c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA Staff. If a modification of existing policy is being proposed, the resolution should set out the pertinent text of the existing policy, citing the policy number from the AMA Policy Database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA Policy Database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

(2) When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA Policy Database.

(3) When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA Policy Database, underlying the directive.

(4) Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.

(5) The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.

(6) All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.

(7) Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
(8) Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:

(a) New HOD Policy;
(b) Modify Current HOD Policy;
(c) Consolidate Existing HOD Policy;
(d) Modify Bylaws;
(e) Rescind HOD Policy;
(f) Reaffirm HOD Policy; or
(g) Directive to Take Action.

(9) Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

Introducing Business to the AMA House G-600.060

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.

2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

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

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

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

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

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

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

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

**Actions and Decisions by the AMA House and Policy Implementation G-600.071**

AMA policy on House actions and decisions includes the following: (1) Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (a) correcting factual errors in AMA reports, (b) rewording portions of a report that are objectionable, and (c) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. (2) A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy. (3) Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

AMA policy on implementation of policy includes the following: (1) Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted. (2) Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions. (3) Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.
Whereas, The Family and Medical Leave Act (FMLA) requires employers with 50 or more employees to grant up to 12 weeks of unpaid annual leave to allow workers to care for a spouse, child, or parent (except in-laws) with a serious health condition, to take leave for personal health conditions, or to care for newly born or adopted children; and

Whereas, The United States Census reports that 80% of American households depart from the nuclear family model of a married opposite-sex couple and their minor children; and

Whereas, The American Society on Aging reports that 64% of LGBT (lesbian, gay, bisexual, transgender) individuals born between 1943 and 1960 develop a “chosen family” – a group of people to whom they are not biologically or legally related but whom they consider family – due to conflict and violence with their biological families; and

Whereas, 16% of LGBT Individuals born between 1943 and 1960 report they would rely on an adult child caregiver for their needs if impaired, as compared to 7% of their heterosexual counterparts; and

Whereas, 42% of LGBT individuals born between 1943 and 1960 state they would depend on close friends in an emergency, as compared to 25% of the general population; and

Whereas, 37% of LGBT youth in juvenile justice settings report homelessness due to family rejection as compared to 17% of their heterosexual counterparts; and

Whereas, In 2015, the American College of Physicians noted that the “definition of ‘family’ should be inclusive of those who maintain an ongoing emotional relationship with a person, regardless of their legal or biological relationship;” and

Whereas, In 2016, The Center for American Progress estimated lack of paid leave costs workers $20.6 billion each year in lost wages, not including reduced savings and retirement income; and

Whereas, In 2017, The National Institutes of Health (NIH) formally designated LGBT individuals as a health disparity population for NIH research due to mounting evidence that LGBT
individuals have reduced access to healthcare and higher burdens of diseases such as
depression, cancer, and HIV/AIDS; and

Whereas, LGBT persons report poorer health as compared to their heterosexual counterparts,
including earlier age at disability, increased risk of sexually transmitted infection among MSM,
decreased likelihood to obtain preventive cervical cancer screening among lesbian women, and
increased incidence of obesity among lesbian and bisexual women; and

Whereas, Results from the 2008 National Health Interview Survey indicated workers with paid
leave are significantly more likely to to see healthcare providers and to receive screenings such
as mammography, Pap testing, endoscopy, and fecal occult blood testing, independent of
insured or uninsured status and health status; and

Whereas, In 2016, a study from the American Journal of Orthopsychiatry asserted that affirming
the chosen family of LGBT individuals in family and medical leave policies improved mental
well-being; and

Whereas, In 2010, the United States Office of Personnel Management issued regulations to
modify its definitions of family member and immediate relative to include “domestic partner and
parents thereof” and “any individual related by blood or affinity whose close association with the
employee is the equivalent of a family relationship” in order to expand the categories of
individuals for whom an employee may use leave; and

Whereas, Arizona, the District of Columbia, Hawaii, Maine, New York, and Oregon have
expanded upon the federal FMLA regulations in favor of the “blood or affinity” model, which
allows FMLA-equivalent benefits for chosen family, domestic partners, and individuals who are
dependent or mutually interdependent on the employed individual; therefore be it

RESOLVED, That Our AMA advocate that Family and Medical Leave Act policies include any
individual related by blood or affinity whose close association with the employee is the
equivalent of a family relationship.

Fiscal note: Significant, 12

Date received: 9/20/17

References:
3. Care of Lesbian, Gay, Bisexual, and Transgender Older Adults Position Statement. J Am
Geriatr Soc. 2015 Feb; 63(3):423-426
The MetLife Study of Lesbian, Gay, Bisexual, and Transgender Baby Boomers”
5. Knauer, N.C. LGBT Older Adults, Chosen Family, and Caregiving. Journal of Law and
Religion. 2016 Jul; 31(2): 150-168
6. Irvine, A. & Canfield, A. “The Overrepresentation of Lesbian, Gay, Bisexual, Questioning,
Gender Nonconforming and Transgender Youth Within the Child Welfare to Juvenile Justice
7. Daniel, H. & Butkus, R. Lesbian, Gay, Bisexual, and Transgender Health Disparities:
Executive Summary of a Policy Position Paper from the American College of Physicians. Annals
of Internal Medicine. 2015 Jul;163(2):135-137
16. 75 FR § 33491 – Absence and Leave; Definitions of Family Member, Immediate Relative, and Related Terms. 2010.
19. N.Y. Workers’ Comp. Law §§ 4; 201(20)
21. Wis. Stat. Ann. §§ 103.10(1)(ar); 40.02(21c)-21(d)
22. D.C. Code Ann. § 32-131.01(C)

RELEVANT AMA AND AMA-MSS POLICY:

65.012MSS Removing Barriers to Care for Transgender Patients: AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician. (MSS Amended Res 11, I-07) (AMA Res 122, A-08 Adopted as Amended in Lieu of AMA Res 114 and 115 [H-185.950]) (Reaffirmed: MSS GC Report C, I-12)

65.013MSS Marriage-Based Health Disparities Among Gay, Lesbian, Bisexual, and Transgender Families: AMA-MSS supports AMA efforts to evaluate existing data concerning same-sex couples and their dependent children and report back to the House of Delegates to determine whether there is evidence of health care disparities for these couples and children because of their exclusion from civil marriage. (MSS Res 5, A-08) (Reaffirmed: GC Rep B, I-13)

65.014MSS Marriage Equality and Repeal of the Defense of Marriage Act: (1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the “Defense of Marriage Act,” as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the gay, lesbian, bisexual, and transgender (GLBT) community. (MSS Res 30, A-10) (AMA Res 209, I-10 Referred) (Reaffirmed: MSS GC Rep D, I-15)
Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976: Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927: Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

Health Care Disparities in Same-Sex Partner Households H-65.973: Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995: Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 4
(I-17)

Introduced by: Region 5 and the State of Connecticut

Subject: Reducing the Use of Restrictive Housing in Prisoners with Mental Illness

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Restrictive housing, commonly practiced in the form of solitary confinement, is defined as “any type of detention that includes removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more;”\(^1\) and

Whereas, Based on available data, there are between 25,000 and 80,000 prisoners in restrictive housing conditions on any given day in America’s prisons and jails, including up to 25,000 in long-term isolation in supermax prisons;\(^2\) and

Whereas, In recent years, studies have suggested that the frequency, duration, and conditions of confinement of restrictive housing, even for short periods of time, can cause psychological harm and significant adverse effects on these inmates’ mental health;\(^3,4\) and

Whereas, According to experts, inmates who have spent long periods in isolation are more likely to recidivate and have a more difficult time creating the lasting social bonds that are necessary for reintegration into society;\(^5\) and

Whereas, Studies have consistently indicated that 8 to 19 % of prison inmates have psychiatric disorders that result in significant functional disabilities;\(^6\) and

Whereas, The adverse effects of restrictive housing are especially significant for prisoners with serious pre-existing mental illnesses;\(^7\) and

Whereas, It is the position of the American Psychiatric Association that inmates with a serious mental illness who are a high suicide risk or demonstrating active psychotic symptoms should not be placed in restrictive housing as previously defined and instead should be transferred to an acute psychiatric setting for stabilization;\(^8\) and
Whereas, It is the position of the National Commission on Correctional Healthcare that mentally ill individuals “should be excluded from solitary confinement of any duration;”\textsuperscript{9} and

Whereas, In July 2017, a Department of Justice (DOJ) report examining the use of restrictive housing for inmates with mental illness by the Federal Bureau of Prisons (BOP) determined that current BOP policies do not adequately address the confinement of inmates with mental illness in restrictive housing units and that the BOP does not sufficiently track or monitor such inmates;\textsuperscript{10} and

Whereas, In order to mitigate the placement of inmates with mental illness in restrictive housing, the DOJ recommends that the BOP, “Assess the scalability of secure residential mental health treatment programs and develop alternatives to address their potential limitations;”\textsuperscript{11} and

Whereas, The BOP has formally agreed with the DOJ recommendation cited above;\textsuperscript{12} and

Whereas, Multiple state and local correctional departments, including but not limited to Nebraska, North Carolina, Oregon, New York City, and Middlesex County, New Jersey, are currently engaged in initiatives to significantly reduce the use of segregated housing through the advancement of safe and effective alternatives;\textsuperscript{13} and

Whereas, our AMA-MSS opposes the use of solitary confinement for the mentally ill (140.028MSS); and

Whereas, our AMA has passed previous policy protecting vulnerable inmate populations, but unlike our AMA-MSS it has no policy regarding the use of restrictive housing or solitary confinement in adults (H-60.922, H-430.990); therefore be it

RESOLVED, That our AMA encourages federal, state, local, and private correctional facilities to explore, develop, and implement alternatives to restrictive housing for inmates with mental illness in order to reduce and ultimately eliminate the use of restrictive housing in this population.

Fiscal note: Moderate, 10

Date received: 9/20/17

References:


5. Craig Haney, Professor of Psychology at the University of California, Santa Cruz, before the Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, U.S. Senate, concerning “Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences” (June 19, 2012), 10–11.


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

**Solitary Confinement of Juveniles in Legal Custody H-60.922**

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

**Bonding Programs for Women Prisoners and their Newborn Children H-430.990**
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
(2) encourage all correctional systems to support NCCHC accreditation;
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical
education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

**Solitary Confinement 140.028MSS**

That our AMA (1) oppose the use of solitary confinement for juveniles or the mentally ill regardless of circumstance; (2) oppose the use of solitary confinement for disciplinary purposes; and (3) support that isolation for clinical or therapeutic purposes must be conducted under the recommendation and supervision of a physician.
Whereas, Communication is one of the foundational aspects of patient care that impacts patient satisfaction and builds rapport between a physician and patient; and

Whereas, Person-first language is a style of communication in which the person is listed first followed by descriptive terms, such as a disease state (e.g. “a person with schizophrenia” rather than “a schizophrenic”), which avoids defining a person by his or her disease state and places the emphasis on the person rather than the disease or disability; and

Whereas, The use of person-first language may improve the doctor-patient relationship, encourage a healthy relationship between researchers and the community, and reduce stigma associated with certain disease states; and

Whereas, Multiple organizations including the United States Center for Disease Control, American Psychological Association, and American Society of Addiction Medicine encourage person-first language; and

Whereas, Person-centered language is a style of communication that incorporates an individual’s preference and identity when referring to a disease state (e.g. “a blind person” or “a person with blindness” based on personal preference), which may deviate from person-first language; and

Whereas, The use of person-centered language focuses on each person’s individual preferences rather than using generalizing terms for a group when referring to a disease state or disability, which seeks to maintain dignity and respect for all individuals; and

Whereas, Certain groups - such as the deaf and the blind communities - speak against using person-first language because they identify their disability as a trait they possess instead of a pathologic process, and this issue is mitigated by using person-centered language; and

Whereas, The Canadian Alzheimer’s Society has developed specific guidelines for using person-centered language as to “not diminish the uniqueness and intrinsic value of each person and to allow a full range of thoughts, feeling and experiences to be communicated,” and to continue to build trusting relationships with these patients regardless of their condition; and

Whereas, The AMA recommends the use of person-first language in the AMA Code of Style, and recently adopted policy regarding the use of person-first language for obesity (H-440.821) but failed to include other disease states; and
Whereas, AMA discussions, resolutions, and reports do not consistently use person-first language where applicable; therefore be it

RESOLVED, That our AMA encourages the use of person-centered language in future discussions, resolutions, and reports when appropriate; and be it further

RESOLVED, That our AMA supports the use of person-first language when a patient-centered conversation has not occurred, is not feasible, or when there is no official position on wording preference for a particular health condition.

Fiscal note: Minimal, 4

Date received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

**Person-First Language for Obesity H-440.821**
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

**AMA Manual of Style > Section 2 Style > Subsection 11 Correct and Preferred Usage > 11.10 Inclusive Language > 11.10.4 Disabilities:**
According to the Americans with Disabilities Act (http://www.usdoj.gov/crt/ada/), “a disability exists when an individual has any physical or psychological illness that ‘substantially limits’ a major life activity, such as walking, learning, breathing, working, or participating in community activities.’
Avoid labeling (and thus equating) people with their disabilities or diseases (eg, the blind, schizophrenics, epileptics). Instead, put the person first. Avoid describing persons as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from, stricken with, maimed). Avoid euphemistic descriptors such as physically challenged or special. Avoid metaphors that may be inappropriate and insensitive (blind to the truth, deaf to the request). For similar reasons, some publications avoid the term double-blind when referring to a study’s methodology.
Note: Some manuscripts use certain phrases many times, and changing, for example, “AIDS patients” to “persons with AIDS” at every occurrence may result in awkward and stilted text. In such cases, the adjectival form may be used.

**Addressing Communication Deficits in Medical School Curricula 295.186MSS**
AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication.
Resolutions: 6
(I-17)

Introduced by: Region 5: Adam Roussas, University of Arizona College of Medicine – Tucson; Christopher Vo, University of California, Irvine

Subject: Protecting Equity in Access to Kidney Dialysis and Transplant

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Chronic kidney disease (CKD) affects nearly ~20 million adult Americans and end-stage renal disease (ESRD) affects ~679,000 adult Americans as of 2014;\(^1\) and

Whereas, CKD is defined as “kidney damage for ≥3 months, as defined by structural or functional abnormalities of the kidney, with or without decreased GFR or GFR <60 mL/min/1.73m\(^2\) for ≥3 months, with or without kidney damage”;\(^2\) and

Whereas, Stage 5 CKD, often interchangeably referred to as ESRD, is a state of severe renal function requiring renal replacement therapy (RRT) or transplant;\(^2\) and

Whereas, Over 400,000 patients a year with ESRD utilize hemodialysis;\(^3\) and

Whereas, Between 2012 and 2014, Medicare spent $32 billion dollars reimbursing care for ESRD patients;\(^1\) and

Whereas, Hemodialysis annually costs over $87,000 dollars per patient while a kidney transplant costs over $32,000 dollars for the procedure;\(^1\) and

Whereas, For ESRD patients, kidney transplant “represents the optimal treatment, providing longer survival, better quality of life, and substantial cost savings compared to dialysis”;\(^4\) and

Whereas, Per the United States Renal Data System (USRDS), hemodialysis patients have a 42% 5-year survival rate compared to deceased donor kidney transplant patients who have a 75% 5-year survival rate and living donor kidney transplant patients who have an 84.6% 5-year survival rate;\(^1\) and

Whereas, A study found that more than 30% of patients with ESRD were not informed of kidney transplant as a treatment option at the time of their submission of Form 2728 (End Stage Renal Disease Medical Evidence Report) for Medicare entitlements;\(^5\) and

Whereas, “Compared to Whites, ESRD prevalence in 2014 was about 3.7 times greater in African Americans, 1.4 times greater in Native Americans, and 1.5 times greater in Asians”;\(^1\) and

and
Whereas, In 2014, Caucasians comprised 42% of deceased kidney donor recipients, Africans Americans comprised 31%, Hispanics comprised 16%, and Asians comprised 7%.

Whereas, In 2014, approximately 86.5% of living donor kidneys came from family, friends, and other individuals known to patients meanwhile Caucasians comprised almost 67% of living transplant recipients, African Americans comprised 12.6%, Hispanics comprised 14%, and Asians comprised 5%.

Whereas, African American race is associated with decreased likelihood of assessment for transplantation, lower transplant wait-listing rates, and greater disparity in the probability of receiving a transplant.

Whereas, Among those initiating dialysis, African Americans and those with non-private insurance have a “lower chance of wait-listing in the first 2 years after adjusting for clinical and demographic factors as well as whether patients had been seen by a nephrologist before starting dialysis”.

Whereas, Variation in provider understanding of and approach to patient transplant education along with poor patient comprehension of kidney transplantation process, wait times, and benefits contribute to disparities in access to and wait-listing for transplantation.

Whereas, Medical, social, and cultural concerns not addressed early in the process can also become barriers, especially amongst African American and Hispanic patients, towards approaching potential donors such as family or friends for undergoing live donor kidney transplant.

Whereas, H.R.2644 Chronic Kidney Disease Improvement in Research and Treatment Act of 2017 has been proposed “to understand the progression of kidney disease and the treatment of kidney failure in minority populations and improve access to kidney disease treatment for those in underserved rural and urban areas”.

Whereas, Efforts to educate and engage minority dialysis patients, especially those attending outpatient dialysis centers, are valuable as they can increase minority patient referrals, reduce racial disparities in transplant, and promote greater informed patient decision-making.

Whereas, National standards or guidelines for transplant education have been suggested as a means of ensuring that all patients who need transplant may benefit from it; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to improve equitable access to counseling and education on the availability, benefits, and risks of all end-stage renal disease treatments, including but not limited to various types of dialysis, procedures, and organ transplantation.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


Relevant AMA and AMA-MSS policy:

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963
1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ. 2. Our
AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs. (Res. 104, A-13)

**Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962**
Our AMA supports federal funding of organ transplants for Medicaid patients. (BOT Rep. 15, A-13)

**UNOS Kidney Paired Donation Program H-370.960**
Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation. (BOT Action in response to referred for decision Res. 2, A-13)

**Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958**
1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation. 2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates. 3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (Res 7, I-15)

**Early Recognition and Intervention in Chronic Kidney Disease D-425.994**
Our AMA will recommend to the United States Preventive Services Task Force that it consider developing guidelines on the screening, diagnosis and staging of chronic kidney disease. (Sub. Res. 521, A-08)
WHEREAS, Implicit bias, also known as unconscious bias, refers to attitudes or preconceived stereotypes that can affect a person’s understanding, actions, and decisions in an unconscious manner; these implicit biases predict behavior in real world settings;¹ and

WHEREAS, Cultural competence is defined as a clinician’s knowledge of other cultures, understanding the importance of culture in patient health behaviors and decision making, and adapting health care practices to meet the cultural needs of the patient;²,³ and

WHEREAS, According to the Department of Justice, cultural competence and implicit bias are different in that, cultural competence training, although may include exploration of personal attitudes and biases, does not inherently incorporate the awareness of implicit biases and the evidence that these automatic, unconscious biases are an independent factor affecting clinical decision making and patient treatment;²,³ and

WHEREAS, Evidence demonstrates physicians across many specialties have implicit bias against multiple demographics, including, but not limited to, African Americans, Hispanics, women, LGBTQI, and obese individuals;⁴,⁵,⁶,⁷,⁸,⁹,¹⁰,¹¹,¹²,¹³,¹⁴,¹⁵,¹⁶,¹⁷,¹⁸,¹⁹,²⁰ and

WHEREAS, Evidence supports that the implicit bias of physicians affects their communication, behaviors, and decision making in their care of patients and leads to disparities in diagnosis, treatment, and health outcomes of patients in multiple demographics, including, but not limited to, African Americans, Hispanics, women, LGBTQI, and obese individuals;¹⁷,¹⁸,¹⁹,²⁰,²¹,²²,²³,²⁴,²⁵,²⁶,²⁷,²⁸,²⁹,³⁰ and

WHEREAS, Implicit bias can be objectively measured using the Implicit Association Test (IAT) which looks at the strength of associations between concepts in the context of individual evaluations, stereotypes, and underlying attitudes;³¹,³²,³³ and
Whereas, A randomized, controlled trial from 2012 supports that the effects of implicit bias can be reduced through educational interventions, and many other studies in the literature support this idea; and

Whereas, Some medical schools have started incorporating implicit bias education into curriculum to address the negative impact of it on patient care; and

Whereas, Other prominent medical organizations, such as the Association of American Medical Colleges, The Joint Commission, and the Institute of Medicine, have acknowledged the existence of implicit bias in medicine and its link to health disparities, and have started to offer educational materials, workshops, and web-based courses on implicit bias; and

Whereas, Existing AMA policy H-295.874 and existing AMA-MSS policy 295.081MSS only address cultural competence, not implicit bias, within undergraduate medical education (UME); and

Whereas, Existing AMA policy D-350.996 is in support of identifying ways of reducing health disparities, yet current AMA policy has not yet identified implicit bias as a contributing factor to health disparities that can be reduced through education; therefore be it

RESOLVED, That our AMA-MSS recognizes the existence of implicit bias among health care clinicians; and be it further

RESOLVED, That our AMA-MSS recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and be it further

RESOLVED, That our AMA-MSS support medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients.

Fiscal note: Minimal, 3

Date received: 9/20/17

References:


Relevant AMA and AMA-MSS Policy:
Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students’ cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations:(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.(BOT Rep. 4, A-03; Reaffirmation A-11)

Strategies for Eliminating Minority Health Care Disparities D-350.996
Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Racial and Ethnic Disparities in Health Care H-350.974
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

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

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

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

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

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878 Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients.

Disparities in Health Care Opinion 8.5
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients’ health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Promoting Culturally Competent Health Care 295.081MSS

Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum 295.181MSS
AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H-295.874])

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development 295.190MSS
Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age. (MSS Res 03, A-16)

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS
AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in
Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate LGBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. 
Whereas, The average American discards over $500 dollars a year in foods and beverages they purchased and did not consume;^1^ and

Whereas, A restaurant discards as much as 10% of food prepared and generates on average 3,000 pounds of food waste per employee annually;^2,3^ and

Whereas, The Environmental Protection Agency (EPA) reported that 40% of food produced within the United States is discarded, comprises over 21% of waste sent to landfills or incinerators, and costs over $1.3 billion dollars to dispose of;^2,4^ and

Whereas, Food waste makes up the single largest category of waste entering landfills, comprises roughly 11% of total greenhouse gas emissions, and as a consequence, makes landfills the 3rd largest source of methane in the country;^5,6^ and

Whereas, The United States Department of Agriculture (USDA) estimated that in 2010, 133 billion pounds of food worth roughly $161 billion dollars went unconsumed;^4^ and

Whereas, The Food and Agriculture Organization of the United Nations estimated in 2011 that “roughly one-third of food produced for human consumption is lost or wasted globally”;^7^ and

Whereas, Achieving a 20% reduction in annual edible food waste translates into an additional 30 billion pounds of edible food per year available for human consumption;^8^ and

Whereas, In 2015, the EPA and the USDA issued a call to action at their 2015 Food Recovery Summit to reduce food loss and waste by 50% by the year 2030;^9^ and

Whereas, The United Nations resolved to halve by 2030 “per capita global food waste at the retail and consumer levels and reduce food losses along production and supply chains, including post-harvest losses”;^10^ and

Whereas, Edible food loss incurs human health costs due to lost calories and nutrients that could have been consumed by the hungry as well as opportunity costs from the natural resources, manpower, and infrastructure invested in the production of that food;^6,11,12^ and
Whereas, A recent study estimated food waste annually accounts for more than 25% of total freshwater and 300 million barrels of oil consumed;\(^1\) and

Whereas, Food rescue is described as the “practice of diverting edible food that would have been thrown out and redistributing this to those in need or those who are food insecure”\(^2\); and

Whereas, Charitable organizations often rely on partnerships with farmers, food enterprises, and other entities to rescue food, combat hunger, and alleviate food insecurity;\(^3\) and

Whereas, While the EPA’s Food Recovery Hierarchy prioritizes utilizing food rescue to feed the hungry, the total amount of edible food currently rescued is still less than 2%;\(^4,5\) and

Whereas, AMA policies H-135.938 and H-135.939 showcase the AMA’s support for community programs aimed at furthering sustainable means of waste reduction and for healthcare professionals to partner with community members in realizing similar initiatives; and

Whereas, H.R. 2428 The Bill Emerson Good Samaritan Act of 1996 was passed to encourage food donations through liability protection for food donors and non-profit organizations, and to resolve confusion on liability for food recovery and donation operations;\(^6,7\) and

Whereas, No federal agency has been tasked with publicizing the Emerson Act and, as a consequence, community awareness regarding protections provided is often limited;\(^8,9\) and

Whereas, While the Federal Food Donation Act of 2008 expanded Emerson Act protections to federal agencies and their affiliates to encourage donation of excess food to non-profit organizations, they are not required to do so and are not required to keep track of donations;\(^10\) and

Whereas, H.R. 952 Food Donation Act of 2017 has been proposed to provide the USDA with oversight and enforcement of the Emerson Act, extend protection to donors who donate food directly to needy individuals, and expand Emerson Act protections to include foods previously mislabeled in ways not directly impacting food safety;\(^11,12\) and

Whereas, Those interested in donating excess food have cited difficulties in participation from fear of liability and negative press coverage to cost and logistical difficulties in transporting donations to reduction or elimination of tax incentives;\(^13,14\) therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to ensure donation of excess food and beverages from its conferences, meetings, and other events; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to advocate for increased awareness of laws and regulations pertaining to and supporting food rescue and donation.

Fiscal Note: Significant, 10

Date Received: 9/20/17

References:


Relevant AMA and AMA-MSS policy:

**AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. (Res. 924, I-16)

**Global Climate Change and Human Health H-135.938**

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08), (Reaffirmation A-14)

**Green Initiatives and the Health Care Community H-135.939**
Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08), (Reaffirmation A-09), (Reaffirmed in lieu of Res. 402, A-10), (Reaffirmed in lieu of: Res. 504, A-16)

Update on the Food and Drug Administration’s Efforts to Improve Food Safety H-150.940
Our AMA: (1) supports regulatory and legislative changes that will empower the Food and Drug Administration (FDA) to implement its “Transforming Food Safety Initiative” built upon the three core principles of (a) prioritizing prevention, (b) strengthening surveillance and enforcement, and (c) improving response and recovery; (2) will monitor the implementation of the “Transforming Food Safety Initiative,” and provide feedback to the FDA as necessary; and (3) urges physicians to remain informed on the diagnosis and management of foodborne illnesses and to report suspected cases of foodborne illnesses to their local public health authority. (CSAPH Rep. 3, A-10)

Sustainable Food D-150.978
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (CSAPH Rep. 8, A-09), (Reaffirmed in lieu of Res. 411, A-11), (Reaffirmation A-12), (Reaffirmed in lieu of Res. 205, A-12), (Modified: Res. 204, A-13), (Reaffirmation A-15)

150.003MSS Hunger in America
AMA-MSS will ask the AMA to: (1) reaffirm its opposition to any further decreases in funding levels for maternal and child health programs and (2) reaffirm its interest in continuing to support efforts to identify national food, diet, or nutrient-related public concerns. (AMA Res 132, A-86 Referred) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11)

135.013MSS Statement of Sustainability Principles
AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10), (Reaffirmed: MSS Res 10, I-11), (Reaffirmed, MSS GC Rep D, I-15)

150.026MSS Programs to Combat Food Deserts:
AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows:
D-150.978 Sustainable Food
“Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the
AMA-MSS Digest of Policy Actions/ 29 development of a healthier food system through the US Farm Bill, tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.
(MSS Res 19, I-12) (AMA Res 204, A-13 Adopted [D-150.978])

150.030MSS Promoting Food Recovery Efforts in Hospitals
AMA-MSS will ask the AMA to support sustainability, better nutrition and improved community health outcomes through hospital food recovery programs by encouraging state medical societies and physicians to collaborate with local hospitals and food recovery programs present in the community. (MSS Res 21, I-14), (Existing Policy Reaffirmed in Lieu of AMA Res 403, A-15)

150.034MSS Identifying and Addressing Food Insecurity and Food Deserts Nationwide
AMA-MSS supports (1) research on the impact of factors influencing functional access to food including but not limited to gentrification, transportation, and crime rates on the development of food deserts; (2) the creation of new tools aimed at identifying food deserts taking into account cost of food in geographically accessible stores or modification of existing tools for identification of food deserts to include consideration of affordability in the establishment of accessibility of healthy food sources; and (3) current efforts by the United States Department of Agriculture in the incorporation of nutrition education programs focusing on sustainable food sourcing and the impact of healthy foods on overall well-being including but not limited to those involving school and community garden building and education on healthy eating habits. (MSS Res 46, A-17)
Whereas, Children are particularly vulnerable to environmental exposures as a consequence of disproportionate food, water, and oxygen consumption relative to body size, and due to lower breathing zones, where certain air pollutants such as mercury tend to accumulate;¹,² and,

Whereas, Between kindergarten and 12th grade, the average school-aged child spends more than 2300 days at school, or over 1170 hours per year;³ and,

Whereas, In the United States, outstanding capital investment and deferred renovations are estimated at over $322 billion,⁴ thereby placing students at significant risk as identified facility shortcomings are left untreated; and,

Whereas, Although the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) offer some protections for teachers and school employees, no parallel organizations exist to safeguard child health, and no legislative or regulatory body holds complete jurisdiction over assessment, remediation, and maintenance of healthy school facilities across all states;⁵ and,

Whereas, The Environmental Protection Agency “does not routinely inspect and enforce...regulations in schools,” with only several acts mandating direct EPA intervention in school settings;⁶-⁹ and,

Whereas, Current FERPA and HIPPA confidentiality rules regarding schools bar reporting of individual school-sourced education and health data, forcing healthcare providers to rely on chronic absenteeism as a substitute for health information;¹⁰ and,

Whereas, Upwards of 600,000 students in New York, New Jersey, Massachusetts, California, and Michigan attend public school located within a half-mile radius of a federally-designated
Superfund (hazardous waste) site or state-designated contaminated site, many of whom are students of color;\textsuperscript{11} and,

Whereas, At least 39 of the 50 United States are known to have schools that supply drinking water with unsafe levels of lead, with “no scientific or practical reason” to assume that this characterization does not in fact apply to every state in America;\textsuperscript{12,13} and,

Whereas, Ninety percent of the schools in America receive water from a local utility rather than private wells, thereby exempting them from EPA guidelines and regulations;\textsuperscript{14} and,

Whereas, Pediatric asthma, a disease resulting in 13.8 million missed school days per year, is directly aggravated by school facilities, with a 200-300\% rise in asthma-related emergency room visits in New York State upon the start of the school year and a subsequent spike following return from school vacations;\textsuperscript{15,16} and,

Whereas, Both carbon dioxide thresholds and ventilation rates in schools consistently fail to meet American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) safety standards;\textsuperscript{17} and,

Whereas, In 2006, only 51.4\% of schools maintained a formal Indoor Air Quality management program,\textsuperscript{18} a number that has fallen in recent years;\textsuperscript{19} and,

Whereas, In a landmark study examining Boston Public Schools, “approximately 85\% of Boston Public Schools reported leaks or water stains, 36\% reported visible mold growth, 63\% reported overt pest signs, 83\% reported repairs needed, and 61\% reported improper chemical storage,”\textsuperscript{20} a reality far from uncommon in both urban and rural settings; and,

Whereas, Urban schools in particular are subject to excessive noise from traffic and local congestion, inciting such health consequences as attention and behavioral deficits, hypertension, increased stress hormones, and emotional symptoms;\textsuperscript{21} and,

Whereas, Children in “poor health” are far more likely to receive B’s, C’s, D’s, and F’s compared to children in “excellent/very good health;”\textsuperscript{22} and,

Whereas, Minority students and already vulnerable populations are more likely to attend underfunded schools with heightened risk of toxic exposures,\textsuperscript{23,24} along with heightened rates of neighborhood violence, both which negatively impact physical and mental health;\textsuperscript{25,26} and,

Whereas, Within the 2010 National School Nurse Survey, 40\% of the 350 nurses interviewed reported personal familiarity with individuals (children and staff) negatively impacted by school pollutants, while over 75\% noted the lack of a designated Indoor Air Quality (IAQ) staff member;\textsuperscript{27} and,
Whereas, When asked why health consequences had gone unreported, these same nurses cited direct discouragement on the part of the school administration; and, 

Whereas, The 2014 School Health Policies and Practices Study conducted by the CDC highlights current shortcomings in school safety inspections, including substandard assessment and remediation of lead, PCB, and mold exposures, indoor air quality, and chemical exposure through the use of unsafe cleaning products; and, 

Whereas, As identified by the Committee to Review and Assess the Health and Productivity Benefits of Green Schools, schools that truly prioritize overall health and performance must establish specific criteria for dryness, indoor air quality, thermal comfort, frequent maintenance/repair, cleanliness, and quietness; therefore be it, 

RESOLVED, That our AMA encourage the federal development and state and local implementation of standardized, comprehensive guidelines for school inspections; and be it further 

RESOLVED, That our AMA promote federal, state, and local policies aiding schools in meeting said guidelines, with an emphasis on both remediation/retrofits and on school facility screening programs; and be it further 

RESOLVED, That our AMA recognize the exceptional needs of schools based in vulnerable neighborhoods, and support policies that offer additional financial and personnel-based aid for screening and remediation of these school facilities; and be it further 

RESOLVED, That our AMA support creation of a streamlined reporting system for school facility health data through application of current health infrastructure (i.e. Pediatric Environmental Health Specialty Units), whose results can be utilized for future research into critical needs and shortcomings.

Fiscal note: Significant, 10

Date received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

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

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

**Childhood Anaphylactic Reactions D-60.976**

Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

**Adolescent Health H-60.981**

It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.

**Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children H-60.950**
Our AMA: (1) encourages physicians to utilize standardized diagnostic criteria in making the diagnosis of ADHD, such as the American Psychiatric Association’s DSM-5™, as part of a comprehensive evaluation of children and adolescents presenting with attentional or hyperactivity complaints; (2) urges that attention be directed toward establishing developmentally appropriate criteria for the diagnosis and treatment of ADHD in adults; (3) encourages the creation and dissemination of practice guidelines for ADHD by appropriate specialty societies and their use by practicing physicians and assist in making physicians aware of their availability; (4) encourages efforts by medical schools, residency programs, medical societies, and continuing medical education programs to increase physician knowledge about ADHD and its treatment; (5) encourages the use of individualized therapeutic approaches for patients diagnosed with ADHD, which may include pharmacotherapy, psycho-education, behavioral therapy, school-based and other environmental interventions, and psychotherapy as indicated by clinical circumstances and family preferences; (6) encourages physicians and medical groups to work with schools to improve teachers’ abilities to recognize ADHD and appropriately recommend that parents seek medical evaluation of potentially affected children; and (7) encourages further research on the relative risks and benefits of medication used to treat ADHD, including evaluation of the impact of labeling changes on access to treatment and physician prescribing.

**School-Based and School-Linked Health Centers H-60.921**

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

**Quality of School Lunch Program H-150.962**

The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.

**Health Instruction and Physical Education in Schools H-170.999**

The AMA reaffirms its long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums, and encourages state and local medical societies to work with the appropriate health education officers and agencies in their communities to achieve this end.

**Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960**

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

**Improving the Health of Black and Minority Populations H-350.972**

Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and
disease prevention activities designed to reduce the occurrence of illnesses that are highly
prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better
understand and reduce the incidence of illness among U.S. minority Americans as
recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school
curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at
teaching skills of health care system access, health promotion, disease prevention, and early
diagnosis.

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

1. Our AMA encourages medical schools, schools of public health, graduate medical education
programs, and key stakeholder organizations to develop and implement longitudinal educational
experiences in public health for medical students in the pre-clinical and clinical years and to
provide both didactic and practice-based experiences in public health for residents in all
specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation
Council for Graduate Medical Education to examine their standards to assure that public health-
related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public
health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share
effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training
programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident
education in public health graduate medical education funding in the Medicare Program and
encourage other public and private funding for graduate medical education in prevention and
public health for all specialties

Combating Obesity and Health Disparities H-150.944

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

Safe Drinking Water H-135.928
Our AMA supports updates to the U.S. Environmental Protection Agency Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:

1. Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water;
2. Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations;
3. Informing consumers about the health-risks of partial lead service line replacement;
4. Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
5. Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health;
6. Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations;
7. Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; and
8. Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act.

**Training in the Principles of Population-Based Medicine H-425.982**

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

**Green Initiatives and the Health Care Community H-135.939**

Our AMA supports:

1. Responsible waste management policies, including the promotion of appropriate recycling and waste reduction;
2. The use of ecologically sustainable products, foods, and materials when possible;
3. The development of products that are non-toxic, sustainable, and ecologically sound;
4. Building practices that help reduce resource utilization and contribute to a healthy environment;
5. Community-wide adoption of ‘green’ initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

**Reducing Lead Poisoning H-60.924**

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e)
urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies H-365.988

Our AMA supports: (1) the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) taking a leadership role in assisting state medical societies in implementation of such programs; and (3) working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy.

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

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational
experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties

**Stewardship of the Environment H-135.973**

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy.
initiatives; (14) encourages physician educators in medical schools, residency programs, and
continuing medical education sessions to devote more attention to environmental health issues;
(15) will strengthen its liaison with appropriate environmental health agencies, including the
National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded
funding for environmental research by the federal government; and (17) encourages family
planning through national and international support.

(MSS Late Res 8, I-14) Optimizing Health Care Cost Reduction through Sustainability
Education and Implementation

The MSS formally establishes support for the following HOD policy:
H-135.939 Green Initiatives and the Health Care Community
Our AMA supports: (1) responsible waste management policies, including the promotion of
appropriate recycling and waste reduction; (2) the use of ecologically sustainable products,
foods, and materials when possible; (3) the development of products that are non-toxic,
sustainable, and ecologically sound; (4) building practices that help reduce resource utilization
and contribute to a healthy environment; and (5) community-wide adoption of "green" initiatives
and activities by organizations, businesses, homes, schools, and government and health care
entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 10
(I-17)

Introduced by: Tabitha Moses, Lauren Newhouse, Taymaz Joneydian; Wayne State University School of Medicine; Julie Bittar; Indiana University School of Medicine; Oscar Reyes Gaido, Johns Hopkins University School of Medicine

Subject: Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, In 2015, more than a half million people in the United States had a heroin use disorder and a further two million had a substance use disorder involving prescription pain relievers; and

Whereas, Of the estimated 1,244,872 emergency department visits involving nonmedical use of pharmaceuticals in 2011, 29% involved narcotic pain relievers; and

Whereas, the rate of overdose deaths involving opioids in the United States increased two hundred percent between 2000 and 2014; and

Whereas, Nineteen states experienced a statistically significant increase in opioid related deaths between 2014 and 2015; and

Whereas, Our AMA recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike (D-95.987); and

Whereas, Little is known about the number of non-fatal overdoses in specific cities and states, though this information could be highly beneficial when implementing real-time, community-specific opioid overdose prevention programs; and

Whereas, Our AMA supports the education of at-risk patients showing signs of opioid overdose and encourages the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose (D-95.987); and

Whereas, Naloxone hydrochloride (Naloxone) is an opioid antagonist that is used to reverse the potentially fatal respiratory depression caused by opioids; and

Whereas, Studies have demonstrated the correlation between more frequently occurring overdose education and naloxone distribution and, greater reduction of overdose related deaths; and

Whereas, Studies have shown that timely naloxone administration was associated with up to 8 times increased odds of survival from an overdose; and

Whereas, It is imperative that health departments and other relevant actors are provided with accurate, timely, and actionable information on drug-related overdose; and
Whereas, There are at least five states (Florida, Arizona, Texas, Rhode Island, and Maryland) that have enacted mandatory overdose reporting policies;¹⁻⁸ and

Whereas, Wisconsin requires law enforcement officials to report overdoses to the state prescription drug monitoring program (PDMP) and West Virginia requires medical professionals to do the same;⁹ and

Whereas, One shared purpose for the introduction of these overdose reporting policies was to allow the for real time monitoring of areas most at-risk, resulting in immediate response through preventative measures (such as Naloxone distribution) to those areas with rises in overdose rates;¹⁻¹³ and

Whereas, The total economic burden associated with prescription opioid overdose and abuse alone is estimated to be $78.5 billion;¹⁴ and

Whereas, The average cost of care per opioid-related admission in urban areas is $92,400;¹⁵ and

Whereas, Healthcare regulations have the potential to increase regulatory burden and certain short-term costs while also lowering future costs;¹⁶,¹⁷ and

Whereas, Mandatory reporting in Baltimore, MD has allowed community health workers to respond immediately to a spike in overdoses with harm reduction such as naloxone and community training to reduce future overdose and opioid-related hospital admissions;¹¹ and

Whereas, Overdose monitoring enables a state’s Department of Health to better understand risk factors for death among those with similar exposures or evaluate the potential benefits of programs put in place to respond to the epidemic;¹¹ therefore be it

RESOLVED, That our AMA support state-mandated, anonymous, non-fatal and fatal opioid overdose reporting to the state health department (or other governmental agency) by first responders and physicians.

Fiscal Note: Minimal, 6

Date Received: 9/20/17

References:

6. Walley AY, Xuan Z, Hackman HH, et al. Opioid over dose rates and implementation of


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

**Increasing Availability of Naloxone H-95.932**

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organization, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.
WHEREAS, Developmental disability is defined by a pediatric transplant center as a “severe, chronic disability of an individual person that is attributable to a mental or physical impairment or combination of mental and physical impairments” that manifests before the person turns 22 years of age;¹ and

WHEREAS, The United Nations has proclaimed individuals with disabilities have the right to access and receive the best obtainable health care without discrimination;² and

WHEREAS, The application of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, which both prohibit health care providers from discriminating based on an individual's disability, has proven complex and nuanced as to what actions are considered discriminatory and non-discriminatory within the context of organ transplantation, needing further clarification and guidance;³ and

WHEREAS, Transplant teams function independently from their institution, having almost complete autonomy in decisions regarding organ allocation and management;⁴ and

WHEREAS, Factors in the evaluation of a potential organ recipient for optimal outcomes include drug and alcohol use, smoking, finances, and medication adherence;⁴ and

WHEREAS, With inconsistent standards across transplant programs, developmental disabilities disorders like autism are additional factors freely considered in a patient’s candidacy as an organ recipient;⁴,⁵ and

WHEREAS, A survey of 50 pediatric heart, liver and kidney transplant programs found that 39% "rarely" or "never" used neurodevelopmental status as a criterion in making decisions on whether to list patients for transplants, 43% "always" or "usually" did so, and there was considerable variation on the incorporation of degree of delay into decision-making;⁵ and

WHEREAS, The advent of objective and subjective metrics such as the World Health Organization’s Disability-Adjusted Life Year and Quality-Adjusted Life Year systems have reinforced the devaluation of individuals with disabilities;³,⁶,⁷ and

WHEREAS, Arguments in opposition of disabled recipients include reduced life expectancy, diminished or absent cognitive skills for post-operative compliance, and lack of improvement to quality of life;⁸ and
Whereas, Literature states that previously established exclusion criteria were rooted in past social values and norms rather than strong medical ethics; and

Whereas, Of individuals with Down Syndrome, 80% live to age 50 or older, and worldwide patients age 65 or older can be candidates for transplantation; and

Whereas, Improvement of functional status in pediatric patients with developmental disability post-liver transplantation was similar to that of pediatric patients without developmental disability; and

Whereas, Adults and children with developmental disabilities have shown long-term transplant benefit and adequate postoperative medication compliance with the appropriate cognitive and social support of family and caregivers; and

Whereas, A multicenter study of renal transplants in disabled patients out of Japan reported an improvement in quality of life for patients and three fifths of caregivers alike; and

Whereas, Under the auspices of the Harvard Ethics Leadership Group, the Community Ethics Committee recommended that all patients with the potential for a minimal threshold of medical benefit be considered for organ transplant listing; and

Whereas, Several state legislatures, including California, Maryland, Oregon and Pennsylvania, have proposed or passed bills to end discrimination against people with developmental disabilities and their access to organ transplantation services; and

Whereas, In October 2016, thirty members of the U.S. Congress implored the Department of Health and Human Services to “issue guidance on organ transplant discrimination with regards to persons with disabilities”; and

Whereas, AMA policy 370.976 highlights the importance of developing and updating policy as needed to ensure proper protections for patients requiring organ transplant; therefore be it

RESOLVED, That our AMA oppose the use of developmental disability in determining a patient’s eligibility for organ transplantation and related services; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to encourage the U.S. Department of Health and Human Services to issue clarification and guidance in providing the developmentally disabled with equitable access to organ transplantation services.

Fiscal note: Significant, 11

Date received:

References:


**RELEVANT AMA and AMA-MSS POLICY:**
Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.

Tissue and Organ Donation H-370.983
Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education.

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.
Amend Federal Law to Allow Clinical Research on the Safety and Effectiveness of HIV-Infected-to-HIV-Infected Organ Transplantation H-370.966

Our AMA adopts a policy position in support of amending the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs and will work to support introduction and enactment of legislation to amend the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs.

Support for Persons with Intellectual Disabilities H-90.967

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (A) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (B) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (C) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (D) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (E) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (F) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at healthcare facilities specializing in care for the developmentally disabled; and (G) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

2. Our AMA seeks: (A) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (B) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (A) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (B) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with
an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.

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

Quality of Care - Essentials and Guidelines for Quality Assessment H-450.995

(1) Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient; (b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources; (f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare; (g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed. (b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable. (c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible. (d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment. (e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach. (f) Both explicit and implicit criteria are useful in assessing the quality of care. (g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.
(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.

(i) The quality assessment process itself should be subject to continued evaluation and modification as needed.

**Support of Human Rights and Freedom H-65.965**

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

**Impairment and Disability Evaluations H-90.977**

It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations.

**Organ Donors and Transplants 370.003MSS**

AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12)
Whereas, Health disparities persist among African American and other ethnic and racial minorities across and despite socioeconomic status (SES), and racial housing segregation is a structural source and amplifier of these racial health disparities;\textsuperscript{1,2,3} and

Whereas, Numerous epidemiologic studies have demonstrated that segregated African American, Hispanic, and other ethnic and racial minority communities face increased rates of infant mortality, obesity, hypertension, asthma, lung cancer, mental health stressors, and psychiatric disorders, among other environmentally-associated adverse health outcomes;\textsuperscript{4,5,6,7,8,9} and

Whereas, The Institute of Medicine, now known as the National Academy of Medicine, has acknowledged that communities of color are disproportionately exposed to environmental burdens and hazards affecting health, including but not limited to lead, air pollutants, and toxic waste due to where they live, and has advocated for the linking of data on environmental health outcomes to data on affected communities;\textsuperscript{10,11} and

Whereas, The AMA has recognized that public education disparities, which fall along racial and economic lines, are a detriment to health (H-60.917), representing a public health and civil rights issue, and research establishes that such disparities are largely due to housing segregation;\textsuperscript{3,12,15} and

Whereas, Despite the passage of the 1968 Fair Housing Act to end discriminatory housing practices that perpetuate race-based segregation, de facto racial housing segregation continues in the form of restrictive zoning favoring low-density development and excluding multi-family housing, predatory loan practices, and the discouragement of people of color or low SES by real estate agents and landlords away from neighborhoods that are majority-white;\textsuperscript{16,17,18,19,20,21} and

Whereas, As of 2010, a third of all metropolitan African Americans continued to live under conditions of housing hypersegregation and as of 2017, racial and ethnic gaps continue to exist in homeownership and housing wealth when comparing African Americans and Hispanics with whites;\textsuperscript{22} and
Whereas, Geographic Information Systems (GIS) data, which can be used to co-locate demographic and mapping data, including housing segregation, with health outcomes has been a critical tool for public health researchers to elucidate and act on health disparities, most notably mapping the Flint water crisis and the disproportionate impact of lead exposure on African American neighborhoods;23,24,25 and

Whereas, The Affirmatively Furthering Fair Housing (AFFH) GIS platform was created in 2015 by the Department of Housing and Urban Development (HUD) Office of Fair Housing and Equal Opportunity to monitor the progress of the 1968 Fair Housing Act, collect and make publicly accessible data on ongoing racial and economic segregation in communities, and examine the disparities in access to education and employment opportunities, and has been lauded by the American Public Health Association as a critical tool in advancing desegregation and improving health outcomes in minority communities;26,27,28 and

Whereas, There is a proposed $6.2 billion slash to the HUD budget for the 2018 fiscal year with prohibitions on funding for advancing the usage of the AFFH tool;29 and

Whereas, There is pending legislation to bar any federal funds to be used “to design, build maintain, utilize or provide access to a federal database of geospatial information on community racial disparities OR disparities in access to affordable housing”;30,31 therefore be it

RESOLVED, That our AMA oppose policies that enable racial housing segregation; and be it further

RESOLVED, That our AMA advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool; and be it further

RESOLVED, That our AMA advocate for the inclusion of Geographic Information Systems (GIS) mapping data in health disparities and health outcomes research.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:

gdesc/title8


RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness. Res. 910, I-16

Racial and Ethnic Disparities in Health Care H-350.974
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

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

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

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


**Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909**
Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources. Res. 404, A-13

**Improving the Health of Minority Populations H-350.961**
Our AMA urges Congress to re-evaluate and expand the federal race and ethnicity categories to include additional ethnic subgroups in order to analyze and uncover racial and ethnic health and healthcare disparities. Res. 906, I-08

**Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984**
Our AMA will pursue avenues to collaborate with the American Public Health Association’s National Campaign Against Racism in those areas where AMA’s current activities align with the campaign. BOT Action in response to referred for decision Res. 602, I-15

**Improving Healthcare of Hispanic Populations in the United States H-350.975**
It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community. (2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community. (3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies. (4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization. (5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics. (6) Promote research into effectiveness of Hispanic health education methods. (7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border. CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08

**Improving the Health of Black and Minority Populations H-350.972**
Our AMA supports: (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities. (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary’s Task Force on Black and Minority Health. (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

**Strategies for Eliminating Minority Health Care Disparities D-350.996**

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. Res. 731, I-02 Modified: CCB/CLRPD Rep. 4, A-12

**Race and Ethnicity as Variables in Medical Research H-460.924**

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients. CSA Rep. 11, A-98 Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11

**Expanding Access to Screening Tools for Social Determinants of Health 160.033MSS**

AMA - MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. MSS Res 03, I – 16; AMA Res 711, A - 17 Referred

**Continuing the Fight to Lower Infant Mortality in the United States 245.012MSS**

AMA - MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, education on healthy choices to reduce risks, and research on how to best reduce infant mortality. AMA - MSS will communicate to the AMA Health Disparities Initiative the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators. MSS Res 26, I – 03; Reaffirmed: MSS Rep E, I – 08; Modified: GC Rep B, I - 13

**Improving Detection, Awareness, and Prevention of Lead Contamination in Water 440.057MSS**

(1) Our AMA-MSS supports future research to improve water sampling techniques and protocols to better detect human exposure to lead at the point of consumption; (2) Our AMA-MSS supports improved open public access to testing data on health hazardous substance levels in public commodities, such as water; and (3) Our AMA-MSS supports legislation and efforts to reduce or eliminate lead from public and private water infrastructure. MSS Res 23, A-16
Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability 135.014MSS
AMA - MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows: Support of Clean Air and Reduction in Power Plant Emissions H-135.949 Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu AMA - MSS Digest of Policy Actions/ 25 135.015MSS of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. (2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. MSS Res 23, A-17
Whereas, The infant mortality in the United States in 2015 was 5.9 per every 1,000 live births;¹ and
Whereas, There were approximately 3,700 cases of sudden unexpected infant deaths (SUID) in the United States in 2015, of which 25% were due to accidental strangulation or suffocation in bed;¹ and
Whereas, The rate of SUID due to accidental strangulation or suffocation has been rising since 1997 to a peak of 23.1 deaths per 100,000 live births in 2015;² and
Whereas, 93% of SUID in New Jersey in 2016 were related to sleep and sleep environments;² and
Whereas, The “Safe to Sleep” educational campaign is credited with decreasing rates of prone infant sleeping leading to reductions in mortality rates from SUID, but these decreases have plateaued in the past decade;³,⁴ and
Whereas, Infants younger than three months of age are significantly more likely to die of causes associated with bed-sharing than other sleep-associated suffocations such as lying prone on a blanket or stuffed animal;⁵ and
Whereas, The rate of bed-sharing from 1993 to 2010 has doubled, and bed-sharing increases the risk of infant death through suffocation;⁶ and
Whereas, Infant bed-sharing is increased among infants with no identifiable place to sleep;⁷,⁸ and
Whereas, Racial, socioeconomic, and geographic disparities exist in the rates of infant death. Black individuals display higher rates of bed-sharing and higher rates of infant death;⁵,⁶ and
Whereas, The American Academy of Pediatrics (AAP) recommends focusing on a safe sleep environment as the primary way to reduce the risk of all sleep-related infant deaths, including SUID;⁴ and
Whereas, The AAP recommends that infants sleep in the supine position and independently on an uncluttered flat surface and “in the parents’ room, close to the parents’ bed, but on a
separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months; and

Whereas, Baby boxes are cardboard boxes with a firm mattress that meet the description of an uncluttered flat surface designed for infants; and

Whereas, Baby boxes are typically equipped with educational materials on newborn care and newborn supplies such as clothing and diapers; and

Whereas, Baby box programs are beginning to be developed in the United States. New Jersey, Alabama, Ohio, Colorado, Texas, and Virginia have developed statewide baby box programs which include a baby box and postpartum supplies, free of charge, upon completion of a 20-minute caretaker educational program; and

Whereas, Unpublished data has shown that when provided the education, bed-sharing is decreased and mothers are more likely to use a baby box as a sleeping place for their infants; and

Whereas, The American Academy of Pediatrics has voiced concerns over a lack of safety research and "insufficient data on the role cardboard boxes play in reducing infant mortality;" and

Whereas, A national program may be difficult to implement by the federal government due to the individual state’s needs due to the variation in demographics, cultural values, and other factors such as climate; therefore be it

RESOLVED, That our AMA encourages the research of baby box safety, efficacy, and methods of implementation as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States.

Fiscal Note: Minimal, 6

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

Sudden Infant Death Syndrome 245.003MSS
AMA-MSS will ask the AMA to encourage the education of parents, physicians, and all other health care professionals involved in newborn care regarding methods to eliminate known SIDS risk factors, such as prone sleeping, soft bedding, and parental smoking.

Continuing the Fight to Lower Infant Mortality in the United States 245.012MSS
AMA-MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, education on healthy choices to reduce risks, and research on how to best reduce infant mortality. AMA-MSS will communicate to the AMA
Health Disparities Initiative the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators.

**Infant Mortality in the United States H-245.986**

It is the policy of the AMA: (1) to work with the World Health Organization toward the development of standardized international methodology for collecting infant mortality data, which will include collecting information regarding racial/ethnic background in order to document the needs of infants, children, and adolescents of subpopulations of society, and will improve the basis on which international comparisons are made; (2) to continue to work to increase public awareness of the flaws in comparisons of infant mortality data between countries, as well as of the problems that contribute to infant mortality in the United States; (3) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (4) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients.

**Infant Mortality D-245.994**

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

**Sudden Infant Death Syndrome H-245.977**

1. The AMA encourages the education of parents, physicians and all other health care professionals involved in newborn care regarding methods to eliminate known Sudden Infant Death Syndrome (SIDS) risk factors, such as prone sleeping, soft bedding and parental smoking.
2. Our AMA will advocate for the appropriate labeling of all infant sleep products, not in compliance with the Safe Infant Sleeping Environment Guidelines, as adopted by the AAP, to adequately warn consumers of the risks of product use and prevent sudden unexpected infant death.
3. Our AMA encourages consumers to avoid commercial devices marketed to reduce the risk of SIDS, including: wedges, positioners, special mattresses, and special sleep surfaces.
4. Our AMA encourages media and manufacturers to follow safe-sleep guidelines in their messaging and advertising.

**Infant Mortality Statistics H-245.998**

The AMA (1) requests that all countries use a standard form of reporting births in their country and the deaths that result per 1,000 live births based on rules and regulations set up by the World Health Organization; and (2) supports publicizing that the medical profession is vitally concerned with infant mortality rates and pledges to continue its efforts to decrease the infant mortality rates in the US to the lowest rate possible.
Introduced by: Andrew Braun, Akshay Goswami, Jayme Trevino, Preeti Singhal, University of Texas School of Medicine at San Antonio; Collin Shumate, Morehouse School of Medicine

Subject: Ending the Risk Evaluation and Mitigation Strategy (REMS) policy on Mifepristone (Mifeprex)

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Medical abortion is a key component of women’s health care because it enables effective, safe, private pregnancy termination without the need for surgical intervention and surgical complications;¹ and

Whereas, The Food and Drug Administration (FDA) often regulates medications by associating them with a drug-specific Risk Evaluation and Mitigation Strategy (REMS), with the goal of ensuring a drug’s benefits outweigh its potential risks²; and

Whereas, The FDA REMS policy states that “Mifeprex must be dispensed to patients only in certain healthcare settings, specifically clinics, medical offices, and hospitals” and prevents the distribution of Mifeprex through retail pharmacies³; and

Whereas, A woman is 14 times more likely to die from pregnancy-related complications than taking Mifepristone (Mifeprex) for a medical abortion;¹ and

Whereas, Only 19 deaths have been reported to the FDA among the more than 3 million women in the United States who have used Mifeprex for medical abortion;¹ and

Whereas, The FDA’s REMS for Mifeprex impedes the provision of Mifeprex, even after over a decade of safe use, without offering any demonstrated or even reasonably likely advantage;¹,⁴ and

Whereas, ACOG and the NEJM, among other prominent organizations, have called for the removal of the Mifeprex REMS given the drug’s history of safe use;¹,⁴ therefore be it

RESOLVED, That the AMA lobby the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone and ensure the drug can be provided in pharmacies nationwide.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS) H-100.961

Our AMA urges that: (1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) require sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; (c) clearly specify that sponsors must assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available; and (d) conduct a long-term assessment of the prescribing patterns of drugs with REMS requirements. (2) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information. (3) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. (4) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner. (5) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend that sponsors assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available. (6) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior. (7) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information. (8) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. (9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent
forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner. (10) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced.

Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation D-100.971
Our AMA will: (1) work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies (REMS) as a means to improve patient safety; and (2) work with the e-prescribing and point of care resource industries to increase physician awareness of REMS as a means to improve patient safety by including current Risk Evaluation and Mitigation Strategy information in their products.

Pregnancy Termination H-5.983
The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

Policy on Abortion H-5.990
The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

Abortion H-5.995
Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Medical Training and Termination of Pregnancy H-295.923
The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

Freedom of Communication Between Physicians and Patients H-5.989
It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient
communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.
Whereas, Over 80% of Americans who experience intimate contact, not necessarily sexual intercourse, will be infected with human papillomavirus (HPV);\textsuperscript{1,2,4} and

Whereas, The spread of HPV is further exacerbated because of its ubiquity and ability to be spread when the individual is asymptomatic at the time of intimacy;\textsuperscript{2,5,7} and

Whereas, Subclinical HPV infection may be as high as 40%, and these individuals are thus unaware that they are infecting others with the virus;\textsuperscript{8,9} and

Whereas, About 14 million Americans are newly infected each year;\textsuperscript{2,10,11} and

Whereas, HPV related diseases harm 1 in every 10 afflicted Americans, which equates to approximately 19,200 women and 11,600 men being diagnosed with an HPV-caused cancer or dysplasia;\textsuperscript{4,9,10,11} and

Whereas, From 2008-2012, HPV-related cancers climbed to 39,000 and of these cases, 28,500 were preventable with the currently available 9-valent HPV vaccine;\textsuperscript{4,6} and

Whereas, Despite Centers for Disease Control and Prevention (CDC) supporting vaccination of boys and girls, US vaccination rates are still low at only 49.5% for girls and 37.5% for boys;\textsuperscript{4,12} and

Whereas, Data demonstrates that a primary reason for poor vaccination rates despite health care coverage and CDC support has been the lack of a strong recommendation by providers;\textsuperscript{7,11,13,14} and

Whereas, The association of HPV vaccination as anti-STI instead of anti-cancer has created
misconceptions for parents and providers, leading to low vaccination rates despite a recent cohort study revealing no association between HPV vaccination and sexual-activity-related outcomes; and

Whereas, Rates of HPV related cervical dysplasia have decreased in the age groups who had HPV vaccination available to them, while those in age groups beyond the recommended vaccination age have stayed stagnant; and

Whereas, Research shows that health care provider (HCP) recommendation correlates strongly with HPV vaccination in females, whilst existing structural barriers as well as perceived low cost-effectiveness has prevented HCP recommendation for males; and

Whereas, Head and neck cancer is the sixth most common cancer worldwide and its ever-increasing incidence is linked to HPV infection; and

Whereas, Current oropharyngeal cancer screening is underdeveloped and uncommon, contributing to the need for increased emphasis of the HPV vaccine as a preventative measure; and

Whereas, Oropharyngeal cancer is more common in males than females; men who received the HPV vaccine had increased levels of both circulating and oral HPV antibodies which may lead to a decrease in the incidence of oropharyngeal cancer; therefore be it

RESOLVED, That our AMA strongly encourage the marketing and promotion of HPV vaccinations as anti-cancer, rather than anti-STI, to all patients; and be it further

RESOLVED, That our AMA encourages reaffirmation of normalizing HPV vaccinations as gender-neutral with regards to marketing; and be it further

RESOLVED, That our AMA-MSS will ask the AMA to amend policy H-440.872 by insertion as follows:


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

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical, vaginal and vulvar cancers in women; penile
cancers in men; and oropharyngeal and anal cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisor

Fiscal note: Moderate, 9

Date received: 9/20/17

References:


**RELEVANTAMA AND AMA-MSS POLICY:**


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

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

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995 (2016)
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 lesions and cervical cancer, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine.

Insurance Coverage for HPV Vaccine D-440.955 (2016)
Our AMA:
(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.
Whereas, The AMA has made it a high priority to “study how costs to students of medical education can be reduced” (H-305.928); and

Whereas, The AMA has existing policy to “better inform applicants about the National Residency Matching Program (NRMP) matching process”, “make recommendations for improvements as the need arises,” and to “limit disparities within the residency application process” (D-310.977), but no similar regarding the Electronic Residency Application System (ERAS); and

Whereas, Beginning in 2017, the Association of American Medical Colleges (AAMC) implemented a mandatory Standardized Video Interview (SVI) for students applying to emergency medicine residency programs through the private company HireVue;¹ and

Whereas, The SVI is designed to evaluate professionalism and interpersonal/communication skills through video-based responses to questions that are numerically scored by third-party “trained raters” at HireVue;¹ and

Whereas, The SVI is limited to interaction with a computer where questions are displayed for 30 seconds and followed by a maximum 3-minute response period;¹ and

Whereas, The AAMC has proposed expansion of the SVI program to applicants of all specialties beginning in 2018;² and

Whereas, The AAMC has not provided any data to support its claim that the SVI fulfills students’ desire for the application to be holistically reviewed;³ and

Whereas, The AAMC is unable to show that the costs related to the SVI and HireVue will not be passed on to medical students as the program is expanded past this year;¹ and

Whereas, The AAMC reports that it is expected that the process of human-review would likely be replaced by computer-based analysis should the SVI expand to other specialties;¹ and
Whereas, Neither the AAMC nor HireVue has demonstrated that computer-based analysis of 
video-responses is non-inferior to human rating; and

Whereas, The AAMC reports that the research pilot showed that the SVI “measures something 
different than academic competency,” but was unable to demonstrate correlation between SVI 
scores and residency placement, performance in residency, or performance in the target 
competencies;² and

Whereas, Data from the research pilot indicates that there are racial/ethnic disparities in the 
scores on the SVI, with Hispanic and Asian interviewees scoring more poorly than white 
interviewees;² and

Whereas, The AAMC has stated that the content-based rubrics according to which evaluators 
will score student responses will not be provided to residency programs;³ and

Whereas, There is no data that SVI scores correlate with other measurements of 
professionalism and interpersonal/communication as assessed by the Medical Student 
Performance Evaluation (Dean’s Letter), ACGME Milestones, or during in-person residency 
interviews; and

Whereas, The AAMC has not announced any plans to release data from the operational pilot;² 
and

Whereas, Medical students have not been invited to participate in the AAMC Emergency 
Medicine Standardized Video Interview Working Group;² and

Whereas, It is in the interest of all stakeholders that the necessity, benefit, cost, and value of 
new ERAS requirements be well understood and justified before being widely implemented; 
therefore be it

RESOLVED, That our AMA work with the Association of American Medical Colleges and its 
partners to advocate for medical students and residents to be recognized as equal stakeholders 
in any changes to the residency application process, including any future working groups related 
to the residency application process; and be it further

RESOLVED, That the AMA advocate for delaying expansion of the Standardized Video 
Interview until data demonstrates the Association of American Medical Colleges’ stated goal of 
predicting resident performance, and make timely recommendations regarding the efficacy and 
implications of the Standardized Video Interview as a mandatory residency application 
requirement; and be it further

RESOLVED, That, given the imminent expansion of the Standardized Video Interview program, 
this resolution be immediately forwarded to the AMA House of Delegates for the AMA Interim 
2017 Meeting.

Fiscal Note: Significant, 12

Date Received:

References:
RELEVANT AMA AND AMA-MSS POLICY:

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928
1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.
2. Our AMA supports stable funding for medical schools to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue and should oppose mid-year and retroactive tuition increases.
3. Financial aid opportunities, including scholarship and loan repayment programs, should be available so that individuals are not denied an opportunity to pursue medical education because of financial constraints.
4. A sufficient breadth of financial aid opportunities should be available so that student specialty choice is not constrained based on the need for financial assistance.
5. Our AMA supports the creation of new and the expansion of existing medical education financial assistance programs from the federal government, the states, and the private sector.
6. Medical schools should have programs in place to assist students to limit their debt. This includes making scholarship support available, counseling students about financial aid availability, and providing comprehensive debt management/financial planning counseling.
7. Our AMA supports legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit the full deductibility of interest on student loans.
8. Medical students should not be forced to jeopardize their education by the need to seek employment. Any decision on the part of the medical student to seek employment should take into account his/her academic situation. Medical schools should have policies and procedures in place that allow for flexible scheduling in the case that medical students encounter financial difficulties that can be remedied only by employment. Medical schools should consider creating opportunities for paid employment for medical students.
9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.
10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.
11. Our AMA opposes any stipulations in loan repayment programs that place greater burdens upon married couples than for similarly-situated couples who are cohabitating.

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

The Grading Policy for Medical Licensure Examinations H-275.953
1. Our AMA’s representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will work with the appropriate stakeholders to study alternate means of scoring USMLE exams in order to avoid the inappropriate use of USMLE scores for screening residency applicants.
Whereas, Chlorpyrifos (CPF) is an organophosphate compound with extensive commercial, residential, and agricultural use in the United States as a general pesticide and insecticide since 1965;¹⁻⁴ and

Whereas, Both prenatal and postnatal exposure to subtoxic levels of CPF have been linked to impaired cognition, poor reflexes, neurodevelopmental delays, and behavioral problems in infants and children;⁵⁻¹⁸ and

Whereas, Although the US Environmental Protection Agency (EPA) banned residential applications of chlorpyrifos in 2000, adverse health effects due to CPF exposure persist and are associated with proximity to agricultural applications, maternal occupational exposure during pregnancy, and children’s consumption of common produce items;¹⁹⁻²⁴ and

Whereas, The EPA revised its human health risk assessment for chlorpyrifos in 2016, noting that dietary exposures amongst population subgroups were 6200⁻¹⁴000% higher than supposed “safe” levels, with children ages 1⁻² at greatest risk;²⁵ and

Whereas, The EPA’s refusal to revoke tolerances for CPF when it cannot ensure with “reasonable certainty that no harm will result to infants and children from aggregate exposure” violates the Food Quality Protection Act (FQPA) of 1996;²⁹⁻³⁰ and

Whereas, The American Academy of Pediatrics stated in an open letter that “the risk [of CPF exposure] to infant and children’s health and development is unambiguous,” emphasizing the ongoing pediatric health risks associated with its continued application;³¹ and

Whereas, The AMA acknowledges the importance of early child brain development and its contribution of health disparities (H-60.917); and

Whereas, Vulnerable populations, including children and the socioeconomically-disadvantaged, are often most impacted by toxic exposures, and yet are oftentimes barred from taking active steps to minimize these exposures;³²⁻³⁸ and
Whereas, Climate change’s impact on agricultural productivity is predicted to result in increased pesticide applications, thereby continuing to disproportionately affect disadvantaged populations,\(^{39-41}\) and

Whereas, The AMA supports the assessment of industrial chemicals’ impact on human health and direct actions to reduce exposures to chemicals of concern (D-135.987, H-135.942); therefore, be it

RESOLVED, That our AMA work with the appropriate stakeholders to educate the public on potential adverse health effects of pesticide exposure, especially for pregnant women, infants, and children; and be it further

RESOLVED, That our AMA support evidence-based measures to revoke tolerances of chlorpyrifos in the United States; and be it further

RESOLVED, That our AMA support implementation and ongoing management of robust pesticide application regulations.

Fiscal Note: Significant, 10

Date Received:

References:


25. US Environmental Protection Agency. Chlorpyrifos: Revised human health risk assessment for registration review. Available at:


RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Modern Chemicals Policies H-135.942
Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Modern Chemicals Policies D-135.987
Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.

Regulation of Endocrine Disrupting Chemicals D-135.982
Our American Medical Association will work with the federal government to pursue the following tenets:
(1) Regulatory oversight of endocrine disrupting chemicals should be centralized such that regulations pass through a single office to ensure coordination among agencies, with the exception of pharmaceutical agents that are regulated by the Food and Drug Administration and are used for medical purposes
(2) Policy should be based on comprehensive data covering both low-level and high-level exposures
(3) Policy should be developed and revised under the direction of a collaborative group comprising endocrinologists, toxicologists, occupational/environmental medicine specialists, epidemiologists, and policymakers
Transgenerational Effects of Environmental Toxins on Reproductive Health H-135.926
Our AMA encourages study of the transgenerational effects of environmental toxins on reproductive health and development.
Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies H-365.988

Our AMA supports: (1) the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) taking a leadership role in assisting state medical societies in implementation of such programs; and (3) working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy.

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

1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;
Bioengineered (Genetically Engineered) Crops and Foods H-480.958

1. Our AMA recognizes the continuing validity of the three major conclusions contained in the 1987 National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a) There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.]

2. That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant or animal, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new bioengineered crops and foods.

3. Our AMA believes that as of June 2012, there is no scientific justification for special labeling of bioengineered foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education.

4. Our AMA supports mandatory pre-market systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly.

5. Our AMA supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers.

6. Our AMA recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing research developments in food biotechnology.

7. Our AMA urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased
information and research activities on bioengineered foods.

135.009MSS Public Notification of Pesticide Applications
AMA-MSS will ask the AMA to support improved public notification of pesticide applications and recommend that clearly visible signs be posted a reasonable time before and after commercial pesticide applications. (AMA Res 403, I-93 Referred) (CSA Rep 4, A-95, Adopted as Amended in Lieu of Res 403 and 404, I-93) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
Whereas, Our AMA supports the Food and Drug Administration’s (FDA) evaluation and approval or disapproval of new drugs or medical devices based on sound scientific evidence as per AMA H-100.992; and

Whereas, The FDA relies on Advisory Committees to review scientific studies of a proposed new drugs or medical devices \(^1\text{,}^2\) ; and

Whereas, FDA Advisory Committees are comprised of experts in the fields of drug safety, clinical trials, and clinical practice, physiology, and pharmacology relevant to the drug or medical device under review \(^1\text{,}^3\) ; and

Whereas, The FDA formally prohibits the hiring of Advisory Committee members with conflicts of interest including employment by the sponsor of the drug under review and stock in the sponsoring company but routinely grants waivers instead of disqualifying such individuals \(^1\text{-}^3\) ;

and

Whereas, The FDA only considers individuals to be conflicted if they have conflicts of interest that occurred in the past 12 months \(^3\text{,}^4\) ; and

Whereas, 12 months is a significantly shorter period to consider conflict of interest compared to the 36 month period that is customary in the scientific community \(^3\text{-}^6\) ; and

Whereas, the FDA in 2007 imposed a cap on the number of conflict of interest waivers that may be granted to Advisory Committee members through the FDA Amendments Act (FDAAA); and

Whereas, The FDA loosened conflict of interest restrictions with the passage of the Food and Drug Safety and Innovation Act (FDASIA) in 2012 by lifting the 2007 cap imposed by the FDAAA on the number of available conflict of interest waivers \(^3\text{,}^4\) ; and

Whereas, The FDASIA deprioritized conflicts of interest by eliminating the weight a financial disclosure had on a candidate’s selection \(^3\text{,}^4\text{-}^7\text{-}^11\) ; and

Whereas, The hiring of Advisory Committee members with conflicts of interest has been shown to impact voting tendencies \(^3\text{,}^4\text{-}^7\text{-}^11\) ; and

Whereas, The impact of Advisory Committee conflicts of interest on voting tendencies introduces bias to the review process and has led to the passage of drugs that were later
recalled due to safety concerns or linked to significant adverse effects such as with the Vioxx and Yaz/Yasmin scandals, respectively\(^3,4,7-12\); and

Whereas, public trust in the FDA among adults is already low at 62.5\% according to national surveys\(^13\); and

Whereas, The use of Advisory Committee Members with direct conflicts of interest undermines public trust in drug safety and presents a possible danger to the public health and safety\(^13,14\); and

Whereas, Research suggests there are a sufficient number of non-conflicted medical experts to fill Advisory Committee vacancies\(^3,15\); and

Whereas, FDA records reflect a rise in productivity and a decrease in advisory committee vacancies under the FDAAA waiver cap policy enacted in 2007\(^3\); and

Whereas, Our AMA has no policy that explicitly objects to the practice of hiring individuals with conflicts of interest to FDA Advisory Committees nor any policy that advocates for increased scrutiny and regulation in matters of conflicts of interest in FDA Advisory Committees; and

Whereas, Our AMA has policy advocating for the use of sound scientific evidence as the basis of drug evaluations (AMA H-100.992) and policy stating that it will monitor and respond to drug safety practices at the FDA (AMA D-100.978); therefore be it

RESOLVED, That our AMA advocate for greater prioritization of conflicts of interest in the Food and Drug Administration’s Advisory Committee member selection process; and be it further

RESOLVED, That our AMA advocate for a reduction in conflict of interest waivers granted to Advisory Committee candidates.

Fiscal Note: Significant, 12

Date Received:

References:


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

**FDA H-100.992**

(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.

(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

**FDA Drug Safety Policies D-100.978**

Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85)
so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. Revision of Dietary Guidelines for Americans AMA-MSS will ask the AMA to: (1) support alterations of “Dietary Guidelines for Americans” only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of “Dietary Guidelines for Americans” should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act (5 U.S.C App. 1, Section 5C). (AMA Res 130, A-83, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) AMA-MSS 150.002MSS

**Doctors Defending Breastfeeding 245.016MSS**

AMA-MSS will ask the AMA to: (1) Discourage hospitals and healthcare professionals from distributing formula and bottles to women who are willing and able to breastfeed; (2) Oppose the marketing or distribution of infant formula in ways that may interfere with the protection and promotion of breastfeeding; and (3) Recognize the inherent conflict of interest present when infant formula manufacturers provide financial support for research into or professional meetings regarding infant and child feeding. (MSS Res 1, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)
Introducing by: Ashleigh A. Omorogbe, Indiana University School of Medicine; Cynthia Abam, Giovanni Rodriguez, Michael Adjei, Julie Bittar, Arvind Haran, Kevin Kuo, Ashleigh Bush, Indiana University School of Medicine; Geetika Srivastava, Northeast Ohio Medical University; Imran Nahin, Case Western Reserve University School of Medicine, AMA-MSS Region V

Subject: Promoting Proportionate Representation of African American Patients in Clinical Trials

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Research has demonstrated that differences exist in response to medical therapies in racially and/or ethnically distinct subgroups of the U.S. population due to intrinsic and extrinsic factors; and

Whereas, An FDA review of drug approvals during the period of 2008 to 2013 found that approximately one-fifth of new drugs demonstrated differences in exposure and/or response across racial and/or ethnic groups; and

Whereas, The NIH Revitalization Act of 1993 requires that all research paid for by the National Institutes of Health (NIH) include enough minorities and women to determine if there are differences to treatment response in certain subgroups. However, only 6% of all clinical trials in 2014 were paid for by the NIH and thus 94% of trials were not required to adhere to these guidelines; and

Whereas, The majority of clinical trials do not reflect the diversity of the patient population afflicted with the disease being studied and African Americans are especially underrepresented making up only 5% of clinical trial participants; and

Whereas, African Americans have a higher morbidity and mortality of many diseases including diabetes, asthma, Alzheimer’s disease, stroke, high blood pressure, and cancer which can be partially attributed to their disproportionate representation in clinical trials; and

Whereas, African Americans have the lowest life expectancy of any racial and/or ethnic group in the U.S., with a life expectancy 3.2 years shorter than the national average; and

Whereas, Research has shown that lifestyle and socioeconomic differences alone cannot account for the health disparities faced by African Americans. Despite lower rates of tobacco exposure, African American men are 37% more likely to develop lung cancer than Caucasian men, and despite lower rates of obesity, African Americans are more likely to have Type II Diabetes than Hispanic Americans; and
Whereas, Metabolic differences among African Americans in many medications, such as warfarin and thiazide diuretics, were not realized during the clinical trial period because of inadequate representation of African Americans in the original clinical trial; and

Whereas, The underrepresentation of African Americans in clinical trials suggests that insufficient data exist to accurately assess the safety and efficacy of new drugs in this population as they relate to genetics, pharmacokinetics, and pharmacodynamics; and

Whereas, African Americans have higher rates of physician distrust in the United States when compared to Caucasians and Hispanics due to reasons such as the notorious United States Public Health Service (USPHS) Study on Untreated Syphilis in the Negro Male at Tuskegee; and

Whereas, Current policy, H-350.971 and H-460.911, advocates for increased resources devoted to minority health issues and recruitment of minorities in medicine, yet the NIH found that African American principal investigators (PIs) are 13% less likely to receive funding when compared to Caucasians and fewer than 2% of NIH PIs are African American; and

Whereas, The lack of diversity in research teams further exacerbates mistrust in African American patients; and

Whereas, Appropriate representation of African Americans in clinical trials will help improve the outcomes of medical therapies in this population and the overall health of all Americans while addressing issues of inequality and health disparities in the U.S.; therefore be it

RESOLVED, That our AMA-MSS support that researchers gather information on the prevalence of African Americans in the U.S. patient population afflicted with the disease being studied prior to patient enrollment in clinical trials; and be it further

RESOLVED, That our AMA-MSS support proportionate representation of African Americans in clinical trials that accurately reflects the disease burden in the African American population; and be it further

RESOLVED, That our AMA-MSS support education on the barriers to enrollment of African Americans in clinical trials to medical students, clinicians, and principal investigators; and be it further

RESOLVED, That our AMA-MSS support education on the clinical importance of proportionate representation of African Americans in clinical trials and the negative health implications of underrepresentation of this subgroup; and be it further

RESOLVED, That our AMA-MSS support efforts and programs that may increase representation of African Americans who enter a career in academic medicine.

Fiscal Note: Minimal, 4

Date Received: 9/20/17

References:
RELEVANT AMA AND AMA-MSS POLICY:

Increasing Minority Participation in Clinical Research H-460.911
1. Our AMA advocates that:
   a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
   b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
   c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
   a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders’ support, and listening to community’s needs;
   b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
   c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
   d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
   e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.
3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association’s policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

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

Our AMA supports increasing the representation of minorities in the physician population by:
(1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
(4) Increasing the supply of minority health professionals.
(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:
(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.
H-460.972 Fraud and Misrepresentation in Science
The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)
American Medical Association
Medical Student Section

Resolution: 20
(I-17)

Introduced by: Daniel Ferman; Conner Holthaus, David Wallington, Yoad Porat, Western Michigan University Homer Stryker M.D. School of Medicine; Sarah Mae Smith, University of California Irvine School of Medicine; Region 5 co-authorship

Subject: Opposition to Measures that Criminalize Homelessness

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Homelessness is a risk factor for hospital admissions and emergency department visits,\(^1,2,3,4\) and

Whereas, Homelessness results in decreased access to healthcare,\(^5,6,7,8,9,10\) and

Whereas, Homelessness contributes to higher hospitalization costs;\(^11,12,13,14,15\) and

Whereas, Homelessness is an independent risk factor for poor health;\(^16,17,18,19\) and

Whereas, Homelessness is correlated with increased mortality;\(^20,21,22,23,24,25,26,27,28,29,30,31\) and

Whereas, Homelessness is an independent risk factor for increased mortality;\(^32,33,34\) and

Whereas, There is a trend in U.S. cities over the past few decades to target homeless persons living in public spaces, using the justice system to criminalize activities necessary for sustaining life;\(^35,36\) and

Whereas, The United Nations Human Rights Committee reports that “criminalization of people living on the street for everyday activities such as eating, sleeping, sitting in particular areas etc.” within U.S. cities “raises concerns of discrimination and cruel, inhuman, or degrading treatment” and that “the State party should engage with state and local authorities to abolish criminalization of homelessness laws and policies at state and local levels”;\(^37\) and

Whereas, The Department of Justice has affirmed the constitutional rights of homeless individuals to sleep in public spaces, stating that it is “uncontroversial that punishing conduct that is a universal and unavoidable consequence of being human violates the Eighth Amendment”;\(^38,39\) and

Whereas, Organizations such as the ACLU have acted in opposition to many anti-homelessness policies;\(^40\) the ACLU of Washington argues that “vague, overly broad, and otherwise discriminatory trespass laws, anti-panhandling ordinances, and other laws can single out and unfairly restrict poor and homeless individuals from exercising the rights and freedoms that every Washingtonian legally enjoys. These laws are ineffective and a waste of public money”;\(^41\) and
Whereas, According to the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, types of criminalization measures against the homeless include, but are not limited to,

- “Legislation that make it illegal to sleep, sit, or store personal belongings in public spaces
- Selective enforcement of more neutral laws, such as loitering or open container laws, against homeless persons
- Sweeps of city areas where homeless persons are living to drive them out of the area, resulting in the destruction of those persons’ personal property, including important personal documents and medications
- Laws punishing people for begging or panhandling in order to move poor or homeless persons out of a city or downtown area”;

Whereas, Policies such as those listed by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty that prohibit “camping”, sitting/lying, loitering, begging/panhandling in certain public places criminalize homelessness without addressing the underlying causes of homelessness and, through exacerbating the problem, lead to poorer health among homeless persons;

Whereas, Criminalization of homelessness leading to arrest for life-sustaining activities advances the development of criminal records among the homeless population, making it more difficult to obtain employment and housing;

Whereas, Criminalization of homelessness is not cost efficient; in a nine-city survey of supportive housing and jail costs, it was found that “jail costs were on average two to three times the cost of supportive housing”;

Whereas, Homeless persons often suffer from poor nutrition, yet many U.S. cities have criminalized the feeding of homeless persons by both private individuals and nonprofit organizations;

Whereas, While homeless encampments reflect a temporary solution to the severe shortage of adequate affordable housing for the number of homeless persons in the U.S., forced evictions of people living in homeless encampments violates the human right to adequate housing;

Whereas, a number of U.S states including Rhode Island, Connecticut, and Illinois have passed Homeless Bills of Rights enacting that all homeless persons have equal rights, including access to emergency medical care and free movement in public spaces without harassment or intimidation, regardless of housing status;

RESOLVED, That our AMA oppose measures that criminalize necessary means of living among homeless persons; and be it further

RESOLVED, That our AMA advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


42. Homes Not Handcuffs: The Criminalization of Homelessness in U.S. Cities, Published by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, July 2009.


44. United Nations Human Rights Committee, List of Issues to be Taken up in Connection with the Consideration of the Fourth Periodic Report of the United States of America (CCPR/C/USA/4), Adopted by the Committee at its 110th Session, 10-28 March 2014 (advance unedited version).


50. Atlanta, Ga., Code of Ordinances ch. 43, § 1 2005.

51. Cleveland, Oh., Code § 605.31 2005.


56. Rhode Island, Bill § S 2052 SUBSTITUTE B. 2012

57. Connecticut, Bill § S.B. No. 896. 2013

58. Illinois, Bill § S.B. No. 1210. 2013

RELEVANT AMA AND AMA-MSS POLICY:

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.
Res 401, A-15

The Mentally Ill Homeless H-160.978
1. The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs.

2. The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences.

3. The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.


Eradicating Homelessness 440.048MSS
Our AMA-MSS will ask the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. MSS Res 33, A-14

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States 440.060MSS
AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

MSS Res 38, I-16; Referred: AMA Res 208, A-17
Resolution: 21
(I-17)

Introduced by: Charles Tsouvalas, Aileen Haque, Alexander Poznanski, Fereshteh Azad, Justin Bria, Wayne State University School of Medicine

Subject: Adverse Impact of Delaying the Implementation of Public Health Regulations

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, It may be necessary to delay the implementation of a public health regulation with justifiable, transparent reasoning in order to adequately address stakeholder concerns and ensure proper compliance; and

Whereas, The Regulatory Freeze Pending Review memorandum issued on January 20, 2017 imposed a blanket 60-day postponement of all regulations published in the Office of the Federal Register that had not yet taken effect for the “purpose of reviewing questions of fact, law, and policy they raise,” but without justifying the postponement of any particular rule; and

Whereas, Between January 20th, 2017 and July 14, 2017 there have been at least 62 delayed rules based on a search of the Federal Registry, which is an 11-fold increase from the same time period in 2016, and a 19-fold increase from the same time period in 2015; and

Whereas, The Environmental Protection Agency (EPA) delayed the implementation of the revised 2015 National Ambient Air Quality Standards (NAAQS) of the Clean Air Act by one year, which is expected to cause an additional approximate 230,000 childhood asthma attacks, 28,000 missed work days and an estimated 660 deaths; and

Whereas, The U.S. District Court of Appeals for the D.C. Circuit’s ruling in Clean Air Council v. Pruitt nullified the EPA’s 1-year delay of revised 2015 NAAQS, since “industry groups had ample opportunity to comment on all... issues on which the EPA granted reconsideration,” and deemed the EPA’s delay “arbitrary,” “capricious” and “unreasonable”; and

Whereas, There are at least 40 additional regulations that potentially have a public health impact with ongoing delays issued within the past eight months, including examples listed below, that have not yet had judicial review on their legality and rationale; and

Whereas, The Labor Department delayed the implementation of the Mine Safety and Health Administration’s rule for workplace safety requirements and examinations in metal and non-metal mines, which is expected to be an effective accident prevention strategy, given that over the past 5 years there have been 110 accidents with 18 fatalities that could have been prevented with the proposed safety requirements; and

Whereas, The 2-year delay of the implementation of the Chemical Accident Safety Rule by the EPA will result in undue harm to employees, given that over the past 10 years there have been

...
1,517 reportable accidents, which led to 58 deaths, 17,099 injuries and approximately 500,000 evacuated people;\textsuperscript{9,10} and

Whereas, The delay in implementation of the Occupational Exposure to Respirable Crystalline Silica by the Occupational Safety and Health Administration (OSHA), which was designed to protect workers at construction sites, is expected to cause 688 preventable deaths per year due to silicosis, lung cancer, and kidney disease, among other causes;\textsuperscript{11-13} and

Whereas, The 18-month delay announced by the FDA in the Federal Food, Drug, and Cosmetic Act is expected to lead to fewer companies printing detailed nutrition facts labels on products, which is expected to lead to a 13\% increase in percent energy from dietary fat consumption in label readers who do not have access to food labels, ultimately increasing obesity-related disease and mortality;\textsuperscript{14-18} and

Whereas, The EPA’s announced two-year delay of the 2016 proposed rule of limiting methane and smog-forming pollutants from oil and gas wells is expected to lead to a 3.2\% increase in asthma diagnoses of adult males and a 4.3\% increase in diagnoses of adult females in the non-smoking population per year;\textsuperscript{19-21} and

Whereas, OSHA announced a minimum two-month delay in implementing protective standards for workers exposed to beryllium, which is expected to lead to an overall increase in diagnosis of chronic beryllium disease in modern mining industry workers exposed to beryllium;\textsuperscript{22-24} and

Whereas, The Department of Transportation’s ongoing delay of Federal Motor Carrier Safety Administration’s training requirements, for licensure of commercial truck and bus drivers, is projected to lead to an average increase of 5 fatal crashes and 102 injury crashes per year;\textsuperscript{25-26} and

Whereas, There are at least six pending lawsuits involving governmental agencies with plaintiffs claiming that the delay of one or more of these regulations has caused undue harm, has not been justified, or has not followed proper procedure;\textsuperscript{27} therefore be it

RESOLVED, That our AMA collaborate with patient advocacy groups and other organizations within the scope of the AMA that are helping to mitigate harm caused by the delay in implementation of public health regulations; and be it further

RESOLVED, That our AMA craft a strong public statement for immediate and broad release, articulating that delaying the implementation of public health regulations can have a significant impact on human health and well-being, and that such delays, when necessary, should be implemented prudently with justifiable, transparent reasoning; and be it further

RESOLVED, That our AMA support future studies that explore the medical consequences of delaying implementation of various public health regulations; and be it further

RESOLVED, That our AMA support the timely implementation of public health policy when feasible and when compelling evidence supporting its implementation to improve public safety is available.
Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


2. See Supplemental Table 1.


27. See Supplemental Table 2

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

**Outcomes Research H-450.973**

1. It is the policy of the AMA to (a) continue to promote outcomes research as an effective mechanism to improve the quality of medical care, (b) urge that the results of outcomes research be used for educational purposes and not as part of punitive processes, (c) promote the use of outcomes research in the development of practice parameters, (d) advocate that findings of outcomes research which identify individual physicians should only be disclosed within formal peer review processes, and (e) monitor outcomes research activities of the federal government, research organizations, and others. 2. The AMA urges state medical societies, national medical specialty societies, hospital medical staffs, and individual physicians to (a) assist organizations in the planning, development, implementation, and evaluation of appropriate outcomes research, (b) identify the significance and limitations of the findings of outcomes research, and (c) ensure that outcomes research is conducted in a manner that protects the confidentiality of patients and physicians. 3. The AMA urges organizations conducting or planning to conduct outcomes research to (a) ensure the accuracy of the data used in outcomes research, (b) include relevant physician organizations and practicing physicians in all phases of outcomes research, including the planning, development, implementation, and evaluation of outcomes research, (c) provide physician organizations and practicing physicians with adequate opportunity to review and comment on interpretations of the results of outcomes research, and (d) ensure that outcomes research is conducted in a manner that maintains patient and physician confidentiality. BOT Rep. K, A-91; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15

**Quality Management H-450.966**

The AMA: 1) Continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and
measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

Injury Prevention H-10.982
Our AMA (1) supports the CDC’s efforts to (a) conduct research, (b) develop a national program of surveillance and focused interventions to prevent injuries, and (c) evaluate the effectiveness of interventions, implementation strategies, and injury prevention programs; (2) supports a Public Health Service public information campaign to inform the public and its policymakers of the injury problem and the potential for effective intervention; (3) supports the development of a National Center for Injury Control at the CDC; and (4) encourages state and local medical societies to support, in conjunction with state and local health departments, efforts to make injury control a priority, and advise the leadership of the United States Congress of this unqualified support; and the AMA remains open to working with all interested parties in efforts to deal with and lessen the effects of violence in our society.
Whereas, In the last five years, the incidence of military child abuse and neglect has risen from 4.8 per 1,000 to 7.2 per 1,000;¹ and

Whereas, When comparing peacetime periods to active war, military families experience an adjusted rate ratio of 1.98 in cases of child abuse and neglect versus 1.08 in civilian families;²,³ and

Whereas, Military families typically relocate often, making it difficult to track instances of child abuse and neglect strictly through state child protective services (CPS);⁴ and

Whereas, The Family Advocacy Program (FAP) within the Department of Defense (DoD) assists in reports of child abuse and neglect in the military when the alleged victim(s) are under age eighteen and/or have a physical or mental incapacity, in addition to being in the legal care of a military personnel, military family member, or DoD sanctioned child care provider;⁵ and

Whereas, The FAP has over 2,000 counselors and specialized clinicians who work to prevent child abuse and neglect in military families through education and treatment of perpetrators and victims;⁶ and

Whereas, HR 3894 was passed in December 2016, requiring individuals of the Armed Forces, DoD employees, or contracted military employees to promptly report known or suspected cases of child abuse and neglect within a military installation to the DoD and state CPS;⁷ and

Whereas, there is currently no reciprocal requirement for state CPS to report known or suspected cases of child abuse and neglect to the FAP;⁸ and

Whereas, The probability of linkage between a military child abuse and neglect case and a FAP report is lower if the treatment occurred in a civilian facility (9.8% in civilian facilities versus 23.6% at military facilities), suggesting decreased communication of military child abuse and neglect from the state to the FAP;⁹ and

Whereas, Fifteen states have enacted laws or enforced policies already in place that require suspected cases of child abuse and neglect brought to CPS also be reported to the FAP;¹⁰ and

Whereas, A coalition in Colorado between the El Paso County CPS and the Family Advocacy Center at Fort Carson that required mutual reporting between CPS and the FAP reduced child abuse and neglect fatalities in the military from 7 deaths in 2011 to 1 in September 2014;¹¹ and
Whereas, Existing AMA policy "supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment" (H-515.960); therefore be it

RESOLVED, That our AMA support all state and federal legislative initiatives requiring child protective agencies to report cases of child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

Fiscal note: Minimal, 6

Date received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

H-515.960 Identifying and Reporting Suspected Child Abuse
1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.

2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.

3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.

4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.

5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.

6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.

7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.

H-515.965 Family and Intimate Partner Violence

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

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

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

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

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

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

H-515.981 Family Violence- Adolescents as Victims and Perpetrators

The AMA (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

A-92, Reaffirmed: A-03, Modified: A-13

Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse 515.007MSS

AMA-MSS will ask the AMA to work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected.
MSS Res 1, I-08, AMA Res 415, A-09 Adopted [D-515.982], Reaffirmed: MSS, I-14
Whereas, Sexual education is important in informing adolescents about biological changes
during puberty, sexual health, and sexual and romantic relationships and a strong foundation in
sexual education promotes healthy sexual relationships, lower rates of teenage pregnancy, and
encourages safe sexual practices later in life;¹,² and

Whereas, As classified by the United States Census Bureau, if a person is a non-native
speaker of the English language and has a limited ability to read, speak, write or understand
English they are considered to have limited English proficiency (LEP);³ and

Whereas, The LEP population in the United States has grown 80% from 1990 to 2013 and has
increased from 6% of the total United States population in 1990 to 8.5% in 2013;³ and

Whereas, The estimated percentage of students with LEP in United States public schools is
9.3%, of which 76.5% speak Spanish/Castilian;⁴ and

Whereas, The highest rates of teenage pregnancy in the United States are in the Latino
community;⁵ and

Whereas, the STI rates for Latina adolescents is approximately two times higher than non-
Latina White adolescents (8.93 and 4.3 per 1000, respectively), and 24% of newly diagnosed
cases of HIV in persons aged 20 to 24 were Latino while 16% were caucasian;⁶,⁷,⁸ and

Whereas, Understanding aspects of Latino culture, such as social class, education,
socioeconomic status, country of origin, religiosity, the changing role of women, the impact of
the media, and view of family planning programs, are crucial for effective sex education efforts
in the Latino community;⁹ and

Whereas, There is evidence that language concordant and culturally competent sexual
education taught both in English and Spanish results in reduced contraction of HIV in Latino
populations, increased days of protected sex, and more frequent condom use;¹⁰,¹¹ and

Whereas, Though the majority of research on LEP learners studied Spanish-speaking
communities, this issue transcends to all LEP learners regardless of language; and
Whereas, AMA policy H-350.957 supports eliminating health disparities in immigrant populations; and

Whereas, AMA policy H-170.968 currently supports comprehensive sex education, it does not encourage schools to use language concordant materials for LEP pupils; therefore be it

RESOLVED, That our AMA will amend policy H-170.968 by insertion as follows:

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

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.
Fiscal Note: Moderate, 9

Date Received:

References:


CURRENT AMA AND AMA-MSS POLICY:
An Updated Review of Sex Education Programs in the United States H-170.962
Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy.

Education on Condom Use H-170.965
Our AMA: (1) Supports joining with appropriate medical and public health organizations and federal agencies in endorsing the use of condoms in reducing the risk of HIV/AIDS and other sexually transmissible diseases among the population; (2) Encourages the production of condom education materials that meet standards of accuracy, completeness, social appropriateness, clarity, and simplicity; (3) Supports cooperating with other medical societies, the public health community, government agencies, and the media to develop standards for public service announcements regarding condom use in prevention of HIV/AIDS and other sexually transmissible diseases; and (4) In cooperation with state, county, and specialty medical societies, encourages physicians to educate their patients about the role of condom use in reducing the risk of sexually transmissible diseases, including HIV disease. While such counseling may not be appropriate for all patients, physicians should be encouraged to provide this information to any patient who may benefit from being more aware of the risks of sexually transmissible diseases.

Human Sexuality Education H-170.966
Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents.

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
Our AMA: (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will
work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

Comprehensive Health Education H-170.977
Our AMA: (1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol abuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribed amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
Resolution: 24

(Introduced by) Gregory de Gruchy, Faith Crittenden, Kate Topalis, Devin Bageac, Andrew Glick, Christine Parsons, University of Connecticut School of Medicine; Elizabeth Godfrey, Central Michigan University College of Medicine.

Subject: Infertility and Infertility Insurance Coverage

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, infertility is defined as the inability to conceive after one year, or longer, of having unprotected sexual intercourse; and

Whereas, one-third of all infertility cases are caused by only male infertility, one-third are caused by only female infertility, and one-third are caused by both male and female infertility or by unknown causes; and

Whereas, in the past 40 years Western males have demonstrated a 52.4% decline in sperm count, occurring at a rate of 1.4% per year, due to unknown causes; and

Whereas, 12% of U.S. women aged 15 to 44 years have difficulty getting pregnant or carrying a pregnancy to term; and

Whereas, 12% of women aged 15-44 and 41% of women aged 25-44 with current fertility problems report using fertility services to help have a baby between the years 2006-2010; and

Whereas, women with insurance coverage for IVF were more likely to attempt multiple rounds of IVF, and had a higher probability of live birth than women paying out-of-pocket for IVF.

Whereas, only 15 states require insurance coverage for female in fertility and only 8 require insurance coverage for male infertility; and

Whereas, high rates of medical trainees and physicians choose to delay childbearing or feel pressured to delay childbearing; and

Whereas, fertility declines with increasing age in both men and women; and

Whereas, disparities in fertility need, use, access, and coverage exist for racial minorities and homosexual women such that heterosexual white women are twice as likely to receive medical help to become pregnant; and

Whereas, historically, sexual and racial minorities have faced barriers that are either financial, social hostility or legal impediments with infertility and infertility coverage; and
Whereas, Our AMA-MSS has no policy whereby our delegates may vocally represent the AMA-MSS’ interests on the topic of infertility; therefore be it

RESOLVED, That Our AMA-MSS formally establishes support for the following HOD policy:

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organization’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

;and be it further

RESOLVED, That our AMA-MSS formally establish support for the following HOD policy:

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.

2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

;and be it further

RESOLVED, That Our AMA-MSS support research into the underlying cause of rising sub- and infertility trends; and be it further

RESOLVED, That Our AMA-MSS supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons.

Fiscal Note: Minimal, 4

Date Received:

References:

https://doi.org/10.1093/humupd/dmx022


RELEVANT AMA AND AMA-MSS POLICY:

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.

2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as
determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

**Recognition of Infertility as a Disease H-420.952**

Our AMA supports the World Health Organization’s designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

**4.2.1 Assisted Reproductive Technology**

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

“Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

(a) Value the well-being of the patient and potential offspring as paramount.

(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.

(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.

(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.

(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.

(g) Participate in the development of peer-established guidelines and self-regulation.

**AMA Principles of Medical Ethics: I, V, VII**

*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 25
(I-17)

Introduced by: Adam Roussas and Danny Hintze, The University of Arizona College of Medicine - Tucson; Gwendolyn Lee, David Geffen School of Medicine at UCLA; Andrew Lin, UCSF School of Medicine

Subject: Healthcare Applications of Blockchain Technology

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Blockchain, most well-known for monetary innovations such as Bitcoin, is a peer-to-peer distributed network technology that allows members of a network to record digital transactions in a shared, public ledger, which is encrypted and referred to as a block, without the need for a central mediating entity;¹,² and

Whereas, Blockchain technology increases accountability between transaction members and improves data security, because each block (i.e. transaction) cannot be edited or deleted, and the distributed, peer-to-peer nature provides a system of seamless data sharing between members of a network (i.e. insurance companies, healthcare providers, hospital networks, and patients);¹,²,³,⁴,⁵ and

Whereas, Potential avenues for applications of blockchain technology to healthcare include public health (identify pandemics), advancing research and clinical trials, managing patient generated data and electronic health records, increasing patient access to personal health records, improving patient security, claims adjudication, and various methods for cost savings;¹,³,⁴,⁶,⁷ and

Whereas, Given the vast potential of blockchain technology, there have been a number of endeavors to explore its applications in healthcare, including Capital One’s collaboration with the health field to improve claims adjudication and billing management and the IBM Watson Internet of Things (IoT) Platform to bridge gaps in device data interoperability while ensuring security, privacy and reliability;⁸,⁹,¹⁰ and

Whereas, The Office of the National Health Information Technology (ONHIT) is actively funding and encouraging the development of health applications for blockchain technology;⁷ and

Whereas, Current AMA policies (D-478.994, D-478.995) have established a precedent for the AMA to work with CMS to support and incentivize interconnectivity and interoperability of EHRs and HITs;

Whereas, Introducing blockchain technology to the field of healthcare faces many challenges including security and privacy concerns; as such, AMA’s involvement and understanding within this space is critical;⁹ therefore be it,
RESOLVED, That our AMA study potential risks and benefits that blockchain technology may have on the healthcare industry, including but not limited to health care costs, security, interoperability, and claims adjudication.

Fiscal Notes: Significant, 11

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

D-478.995 - National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality,
safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

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

**Health Information Technology D-478.994**

Our AMA will:

1. support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);
2. pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;
3. support initiatives to ensure interoperability among all HIT systems; and
4. support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

**Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities D-478.981**

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.

**Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976**

1. Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician
education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.

2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.

3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals
Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources
Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.
Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 26
(I-17)

Introduced by: Kian Adabi, Aaron Burkenroad, Michael Fattouh, Albert Einstein College of Medicine;

Subject: Patient-Reported Outcomes in Gender Confirmation Surgery

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, There are 1.4 million transgender adults in the USA; [1] and
Whereas, Our AMA supports collaboration with relevant organizations to provide education and information that allows for the “provision of high quality and culturally competent care to LGBT people”; [H-160.991] and
Whereas, The American Medical Association, the American Psychiatric Association, the American Academy of Family Physicians, and the American Congress of Obstetricians and Gynecologists recognize that transition-related healthcare interventions, which include gender confirmation surgery, are essential to the mental and physical health of transgender patients; [H-185.950][2][3][4] and
Whereas, The Affordable Care Act provides protection against discrimination on the basis of sex and gender identity; [5] and
Whereas, There were 3200 gender confirmation surgeries performed in 2016 in the United States, which represents a 20% increase from the previous year; [6] and
Whereas, Gender confirmation surgeries include a variety of surgical procedures such as transfeminine and transmasculine genital reconstruction, breast surgery, and facial reconstruction; [7] and
Whereas, There are currently a number of safe and reliable surgical options for patients undergoing gender confirmation surgery, there is currently no standard for patient selection and education about the various techniques available; [8][9] and
Whereas, Patient-reported outcomes are emerging as a standard in the evaluation of and research into surgical quality and outcomes; [10] and
Whereas, A questionnaire that assesses a patient’s perspective on their physical, sexual, and social well-being following breast reconstructive surgery has been validated for use in assessing procedure outcomes and quality; [11] and
Whereas, Current research in gender confirmation surgery outcomes utilizes patient questionnaires related to sexual function and bowel and urinary issues that were not originally designed for the transgender population [12]; and
Whereas, Information gathered from patient-reported outcomes could improve techniques used by surgeons, provide better training, and help new patients better understand how these operations impact overall well-being and quality of life; [13] therefore be it

RESOLVED, That our AMA supports initiatives and research to establish standardized protocols for patient selection, surgical management, and preoperative and postoperative care.

RESOLVED, That our AMA support development and implementation of standardized questionnaires specific to transgender patients that can give researchers and surgeons the tools to appropriately evaluate outcomes of gender confirmation surgery.

Fiscal Note: Minimal, 6

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

H-185.950 Removing Financial Barriers to Care for Transgender Patients
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (Res. 122A-08; Modified: Res. 05, A-16)

H-160.991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

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

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

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


H-460.907 Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients
Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. (Res. 512, A-11)
**D-345.994 Increasing Detection of Mental Illness and Encouraging Education**

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

   (Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16)

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

   (Res 412, A-06; Appended: Res 907, I-12)

**345.007MSS Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications**

AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards’ practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician’s private health record confidentiality by requiring access to these records when an applicant reports treatment. (MSS Res 17, I-13)

**345.009MSS Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools**

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)
Whereas, Medical devices are required to list only certain ingredients specified by the FDA, and the FDA does not require specific tests for cosmetics ingredients;\textsuperscript{1,2} and

Whereas, The FDA currently lists feminine hygiene products such as tampons and absorptive pads as medical devices and feminine hygiene products such as cleansing wipes as cosmetics;\textsuperscript{1,3} and

Whereas, The vagina is a mucous membrane with a dense vascular network that makes it an effective route for drug absorbance, with the ability to secrete and absorb fluids at a higher rate than skin;\textsuperscript{4,5} and

Whereas, Yeast infections and allergic reactions can occur after a reaction between a product and the vagina;\textsuperscript{6} and

Whereas, Even small exposures to such toxic chemicals can lead to health problems;\textsuperscript{5} and

Whereas, Toxic Shock Syndrome (TSS) has been shown to be due in part to materials used in tampons and removal of this material drastically reduced the number TSS outcomes;\textsuperscript{7} and

Whereas, The FDA requires reporting of ingredients in tampons only when related to Toxic Shock Syndrome;\textsuperscript{5} and

Whereas, Toxic products such as dioxin can be found in some feminine hygiene products;\textsuperscript{8} and

Whereas, Some plastics in tampon applicators and fragrances have been shown to have phthalates, which can disrupt development;\textsuperscript{5} and

Whereas, The effects of scents and other products in feminine hygiene products on the vagina and vulva are greatly unknown, but women who reported frequently douching have a 150% higher exposure to diethyl phthalate, which may cause birth defects in babies and has also been linked to gynecologic cancers and endocrine disruption;\textsuperscript{9} and

Whereas, Women age 18 to 34 are known to be heavy buyers of beauty and personal care products listed as cosmetics, which contain multiple chemicals that can render women and their offspring increasingly vulnerable during sensitive periods such as pregnancy;\textsuperscript{9} and

Whereas, Women of color, particularly Dominican-American and Mexican-American women, are more likely to utilize products such as skin lightening face creams which often contain hidden
ingredients including topical steroids or mercury, resulting in several cases of mercury poisoning following usage;\textsuperscript{10,11,12} and

Whereas, Compared with their white counterparts, African American women are twice as likely to experience social pressure to straighten their hair with chemical straighteners or relaxers that contain parabens and estrogens and can trigger premature reproductive development, and possibly uterine tumors,\textsuperscript{13,14,15,16,17,18,19} and

Whereas, Compared to their white counterparts, African American women are more likely to use vaginal douches, fragranced feminine cleansing products such as sprays and wipes, and also talc powder on the genitals- a practice associated with a 24\% increased risk of ovarian cancer;\textsuperscript{9,20,21,22,23} and

Whereas, Low-income women of color are more likely to live in environments with high levels of pollutants contaminating the air, soil and water, thus heavy use of beauty products may add to overall burden of exposures to toxic chemicals already in the home and neighborhood;\textsuperscript{3,9,20,21} therefore be it

RESOLVED, That our AMA support improved ingredient testing and research investigating ingredients that may be harmful in cosmetic and feminine hygiene products; and be it further

RESOLVED, That our AMA support health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products.

Fiscal Note: Minimal, 6

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY

Tax exemptions for feminine hygiene products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.

National Cosmetics Registry and Regulation H-440.855
Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially effect the manufacturers; proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.

Support the distribution of readily available feminine hygiene products in publicly funded institutions 160.032MSS
Feminine Hygiene Products: Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelter. (MSS Res 17, I-16)

National Cosmetics Registry and Regulation 270.021MSS
AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all cosmetics and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall cosmetic products determined to be harmful based on the FDA’s product recall classifications. (MSS Amended Res 11, A-09) (Reaffirmed: MSS GC Rep A, I-14)
Whereas, Women who are pregnant and acquire sexually transmitted infections (STIs) like, chlamydia, gonorrhea, or syphilis are at risk for pregnancy complications such as preterm birth and neonatal infections;  

Whereas, Most chlamydia and gonorrhea infections are asymptomatic in women and therefore can only be identified through routine screening;  

Whereas, STIs such as chlamydia, gonorrhea and syphilis have been on the rise in the United States, with the Center for Disease Control’s (CDC) most recent surveillance data showing that total number of combined cases reached 1,945,874, the highest number ever;  

Whereas, between 2008-2011, approximately 7.7% of pregnant women screened positive for chlamydia, and 0.8% for gonorrhea;  

Whereas, From 2011-2015 there was a 36.3% increase in congenital syphilis mainly due to the failure of healthcare providers to follow maternal syphilis screening guidelines and limited prenatal care;  

Whereas, Pregnant women are eligible for healthcare coverage through any qualified health plans in the Health Insurance Marketplace through the Affordable Care Act or, if low income, through Medicaid;  

Whereas, The current 2015 CDC Guidelines recommend all pregnant women to be tested for syphilis, and pregnant women under 25 or at risk to be tested for chlamydia and gonorrhea;  

Whereas, The American College of Obstetrics and Gynecology (ACOG) and American Association of Pediatrics (AAP) 2017 guidelines recommend following the CDC guidelines on STI screening in pregnancy;  

Whereas, The United States Preventative Services Task Force (USPSTF) gives an A rating to syphilis screening during pregnancy, and a B rating to testing for chlamydia and gonorrhea during pregnancy in women under 24;  

Whereas, The USPSTF lists cites small to none potential harms of screening for gonorrhea, chlamydia, and syphilis;  

Whereas, The United States Preventative Services Task Force (USPSTF) gives an A rating to
Whereas, Cost-benefit analyses predicted that universal screening for chlamydia in pregnancy in a high burden setting would increase expenditures but would lead to significant reductions in morbidity and scaling up screening for syphilis in pregnancy would lead to net savings;¹¹-¹² and

Whereas, Forty-six states mandate syphilis screening for pregnant women;⁸,¹³ and

Whereas, Despite recommendations by the CDC, ACOG, and AAP, a three-year study published in 2012 showing that of around 1.3 million pregnant women, only approximately 59% and 57% of pregnant women were tested for chlamydia and gonorrhea respectively;¹⁴ and

Whereas, The AMA currently has policy regarding HIV screening for pregnant women, but no such policy regarding chlamydia, syphilis, and gonorrhea screening; therefore be it

RESOLVED, That our AMA advocate for universal syphilis screening for all pregnant women; and be it further

RESOLVED, That our AMA support the most up to date and research-based United States Preventative Services Task Force and Center for Disease Control’s recommendations on gonorrhea and chlamydia screening for pregnant women.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

**Sexually Transmitted Disease Control H-440.996**

Our AMA (1) supports continued action to assert appropriate leadership in a concerted program to control sexually transmitted disease;

(2) urges physicians to take all appropriate measures to reverse the rise in sexually transmitted disease and bring it under control;

(3) encourages constituent and component societies to support and initiate efforts to gain public support for increased appropriations for public health departments to fund research in development of practical methods for prevention and detection of sexually transmitted disease, with particular emphasis on control of gonorrhea; and

(4) in those states where state consent laws have not been modified, encourages the constituent associations to support enactment of statutes that permit physicians and their co-workers to treat and search for sexually transmitted disease in minors legally without the necessity of obtaining parental consent.

**Treatment of Chlamydia Trachomatis H-440.900**

Our AMA: (1) supports the application of strategies used to control sexually transmitted diseases (i.e., screening, counseling, treatment, contact tracing) for the prevention and control of chlamydia trachomatis and (2) encourages physicians to participate in strategies for prevention and control of chlamydia trachomatis.

**Increase in Venereal Disease H-440.999**

The AMA takes official cognizance of the resurgence of syphilis and gonorrhea to the proportions of a national health problem; supports initiating through appropriate channels of the AMA a comprehensive inquiry of the causative factors for this sharp increase in diseases for which a simple cure is now available; supports taking the leadership in educational and research measures designed to control and eliminate syphilis; and
supports providing guidance to private physicians in the epidemiology of the venereal diseases and of their social implications.

Research and Control of Gonorrhea H-440.997

Our AMA reaffirms its concern and urges additional support of research and control of gonorrhea, and urges constituent and component medical associations to increase their educational activities and to participate in cooperative programs at the local level to encourage prevention, reporting and prompt adequate treatment of gonorrhea.

Routine HIV Screening D-20.992

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

Control of Sexually Transmitted Infections H-440.979

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

Update on Sexually Transmitted Infections H-440.983

The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted infections (STI), so that they will be better able to diagnose and treat them; (2) encourages physicians to always include a sexual history as part of their routine history and physical exam; (3) encourages STI instruction, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of STI fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote STI public service TV and radio announcements in their communities; and (6) supports continued communication of updated STI information regularly through AMA publications.
HIV and Public Health Prevention Services D-20.989

Our AMA will work with the Centers for Disease Control and Prevention to develop Comprehensive Risk Counseling and Services to be offered to persons reported with HIV infections that are modeled after those provided for persons reported with sexually transmitted diseases.

Clinical Training in STD for Medical Students/Physicians in Training H-295.980

The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training.

Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection.

HIV Testing H-20.920

(1) General Considerations a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive; b) HIV testing should be consistent with testing for other infections and communicable diseases; c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing; d) The physician’s office and other medical settings are the preferred settings in which to provide HIV testing; e) Physicians should work to make HIV counseling and testing more readily available in medical settings. (2) Informed Consent Before HIV Testing a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing; b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care; c) It is the policy of our AMA to review the federal laws including the Veteran’s Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities; d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care; (3) HIV Testing Without Explicit Consent a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection; b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing; c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection; d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing...
of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient (4) HIV Testing Procedures a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis; b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy; c) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result; d) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection; e) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate Western blots or other confirmatory procedures; f) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved. (5) Routine HIV Testing a) Routine HIV testing should include appropriately modified informed consent and modified pre-test and post-test counseling procedures; b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient; (c) State medical associations should review and seek modification of state laws that restrict the ability of hospitals and other medical facilities to initiate routine HIV testing programs; (d) Encourages a review of the evidence for routine HIV testing by the US Preventive Services Task Force; and (e) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers. (6) Voluntary HIV Testing a) Voluntary HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures; b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If voluntary HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing. (7) Mandatory HIV Testing a) Our AMA opposes mandatory HIV testing of the general population; b) Mandatory testing for HIV infection is recommended for (i) all entrants into federal and state prisons; (ii) military personnel; (iii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception; c) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances. (8) HIV Test Counseling a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an
individual presents to a physician with concerns about possible exposure to HIV, or when a
history of high-risk behavior is present; b) Post-test information and interpretation must be given
for negative HIV test results. All negative results should be provided in a confidential manner
accompanied by information in the form of a simple verbal or written report on the meaning of
the results and the offer, directly or by referral, of appropriate counseling; c) Post-test
counseling is required when HIV test results are positive. All positive results should be provided
in a confidential face-to-face session by a professional properly trained in HIV post-test
counseling and with sufficient time to address the patient’s concerns about medical, social, and
other consequences of HIV infection. (9) HIV Testing of Health Care Workers a) Our AMA
supports HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer’s expense, serologic
testing for HIV infection to all health care workers who have documented occupational exposure
to HIV; c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges; d)
Physicians and other health care workers who perform exposure-prone patient care procedures
that pose a significant risk of transmission of HIV infection should voluntarily determine their
serostatus at intervals appropriate to risk and/or act as if their serostatus were positive. The
periodicity will vary according to locale and circumstances of the individual and the judgment
should be made at the local level. Health care workers who test negative for HIV should
voluntarily redetermine their HIV serostatus at an appropriate period of time after any significant
occupational or personal exposure to HIV. Follow-up tests should occur after a time interval
exceeding the length of the “antibody window. (10) Counseling and Testing of Pregnant Women
for HIV Our AMA supports the position that there should be universal HIV testing of all pregnant
women, with patient notification of the right of refusal, as a routine component of perinatal care,
and that such testing should be accompanied by basic counseling and awareness of
appropriate treatment, if necessary. Patient notification should be consistent with the principles
of informed consent. (11) HIV Home Test Kits a) Our AMA opposes Food and Drug
Administration approval of HIV home test kits. However, our AMA does not oppose approval of
HIV home collection test kits that are linked with proper laboratory testing and counseling
services, provided their use does not impede public health efforts to control HIV disease; b)
Standardized data should be collected by HIV home collection test kit manufacturers and
reported to public health agencies; c) A national study of HIV home collection test kit users
should be performed to evaluate their experience with telephone counseling; d) A national
interagency task force should be established, consisting of members from government agencies
and the medical and public health communities, to monitor the marketing and use of HIV home
collection test kits. (12) College Students Our AMA encourages undergraduate campuses to
conduct confidential, free HIV testing with qualified staff and counselors.

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

An Updated Review of Sex Education Programs in the United States H-170.962
Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy.
Whereas, Nearly two-thirds of older adults suffer from hearing impairment and the prevalence of hearing loss doubles with every decade of life\(^1\); and

Whereas, Mild, moderate, and severe hearing loss are known modifiable risk factors in adults aged 65 and older to earlier onset of dementia, more severe course of dementia, increased hospitalizations, prolonged hospitalizations, increased re-hospitalizations, greater risk of falling, and higher incidence of depression and loneliness\(^2\,\,4\); and

Whereas, Hearing loss obstructs management of other chronic conditions, increasing risk of complications and additional healthcare costs\(^5\); and

Whereas, Hearing aids are used by less than thirty percent of adults aged 70 and over who could benefit from their use\(^6\); and

Whereas, The average cost of a single hearing aid is $2400 with doubled out-of-pocket costs for bilateral impairment\(^7\); and

Whereas, Fifty percent of hearing-aid consumers cite lack of Medicare Part B coverage as a barrier to usage\(^8\); and

Whereas, Greater than 20 states do not cover hearing aids and related services to eligible Medicaid recipients\(^9\,\,5\); and

Whereas, Bundling of costs for audiologic services (e.g., hearing test) with hearing aids limits transparency and poses a financial barrier to seeking hearing loss treatment\(^5,\,10\); and

Whereas, Medicare expenditure for preventable downstream consequences of untreated hearing loss is costly\(^5\); and

Whereas, Medicare covers invasive surgeries (i.e., cochlear implants) for hearing loss which could be prevented or delayed with hearing aids\(^10\); and

Whereas, Outside of hearing loss care, Medicare covers both devices/technologies (e.g., wheelchairs, speech-generating device) and associated habilitative and rehabilitative services provided by occupational therapists, physical therapists, and speech-language pathologists\(^5\); and
Whereas, Hearing loss hinders self-independence, placing undue physical and social burden on caregivers of those with hearing loss who in turn utilize Medicare for their own disability; and

Whereas, Several other countries offer public coverage for basic hearing aids and related services, including Australia, Denmark, Finland, Germany, Switzerland, and the UK; therefore be it

RESOLVED, That our AMA support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; and be it further

RESOLVED, That our AMA support Medicare coverage of hearing aids and associated services for at least adults with moderate hearing loss (i.e., 40 - 70 dB) before which cochlear implants are indicated (i.e., >70 dB); and be it further

RESOLVED, That our AMA advocate to state medical societies and professional societies to support policy for increased coverage of hearing aids and associated services for Medicaid beneficiaries; and be it further

RESOLVED, That our AMA encourage Centers for Medicare and Medicaid Services to "unbundle" audiologic services with costs for hearing aids to improve access to treatment and increasing transparency for hearing aid technologies.

Fiscal Note: Significant, 11

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.

2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.

3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.

4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
Whereas, The Association of American Medical Colleges (AAMC) has defined underrepresented minorities (URMs) in medicine as “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population” since 2003;¹ and

Whereas, In 2016, the AAMC Report on Diversity in Medical Education noted that considering diversity as referring solely to race and ethnicity is too narrow and that broadening the definition of diversity would help to encompass sexual orientation, religion, geography, disability, age, language, and gender identity;² and

Whereas, In 2015, the American College of Physicians emphasized the need for “programs that would help recruit LGBT (lesbian, gay, bisexual, transgender) persons into the practice of medicine and programs that offer support to LGBT medical students, residents, and practicing physicians;”³ and

Whereas, In 2014, the National Summit on Cancer in the LGBT Communities advocated for targeted efforts to recruit LGBT-identified individuals as an underrepresented population in academic and training programs and to ensure LGBT-affirmative training environments and mentoring opportunities to alleviate health disparities among LGBT patients;⁴ and

Whereas, The National Institutes of Health (NIH) formally designated sexual and gender minorities (SGMs) as a health disparity population for NIH research due to mounting evidence that SGM populations have less access to healthcare and higher burdens of diseases such as depression, cancer, and HIV/AIDS;⁵ and

Whereas, In 2015, it was found that, among a cohort of Black sexual minority women, 46.2% had a negative health care experience due to discrimination because of their sexual orientation, leading to reduced healthcare utilization in 34% of patients;⁶ and

Whereas, Two-thirds of LGBT physicians have heard disparaging remarks about LGBT people at work, one-third have witnessed discriminatory care of a LGBT patient, and one-fifth have experienced social ostracism because of their LGBT identity;⁷ and
Whereas, Only 9% of US academic medical practices have procedures for connecting patients to LGBT-friendly physicians, only 4% have policies for identifying those physicians, and only 15% have lists of providers comfortable seeing LGBT patients; and

Whereas, In 2015, a study in *The American Journal of Public Health* showed the majority of heterosexual healthcare providers reported moderate to strong implicit preference for heterosexual patients over homosexual patients, while gay and lesbian providers showed more implicit preference in favor of homosexual patients; and

Whereas, Additional studies have demonstrated significant increases in self-breast exam and mammography among lesbian and bisexual women seen by lesbian and bisexual female providers, and increased prescribing of HIV pre-exposure prophylaxis to at-risk patients seen by gay male providers; and

Whereas, In 2013, a study published in *Academic Medicine* by the Senior Director of Diversity Policy and Programs for the AAMC showed that 41.4% of academic health centers already consider LGBT individuals a target population for diversity programs and further emphasized that more expansive definitions of URM do not diminish the recruitment of ethnic minorities so long as data on individual groups remain stratified; and

RESOLVED, That our AMA advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; and be it further

RESOLVED, That our AMA issue a statement of support to expand the definition of “underrepresented in medicine” to include LGBT individuals.

Fiscal note: Significant, 12

Date received: 9/20/17

References:


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

**Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322** – Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity. Res. 313, A-09 Modified: CME Rep. 6, A-11

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

**Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population 65.008MSS** – Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population: AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include “sexual orientation, sex, or perceived gender” in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: “This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender.” (MSS Res 27, A-03) (AMA Res 414, A-04 Adopted [D-65.996])


**Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers 65.017MSS** – AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations. (MSS Res 13, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 304, A-12)

**Strategies for Enhancing Diversity in the Physician Workforce H-200.951** - Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's
Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16


Medical Staff Development Plans H-225.961 – All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. 2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878 – Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2)
supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11)
Whereas, Health care-associated infections (HAIs) are defined as infections that people acquire while receiving treatment for another condition in health care settings, with an estimated 1 in 25 hospital patients in the US having an HAI, amounting to $33 billion in preventable annual healthcare costs;\textsuperscript{1, 2} and

Whereas, Roughly 3 out of every 4 HAIs that occur in an acute care hospital setting are a result of central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSIs), methicillin-resistant staphylococcus aureus (MRSA), or clostridium difficile (C. difficile);\textsuperscript{1, 2} and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths in the United States annually and 700,000 deaths worldwide annually, with deaths related to antimicrobial resistance (AMR) projected to be 10 million people annually by 2050, which is greater than projected annual deaths related to cancer;\textsuperscript{3, 4, 5, 6, 7, 8} and

Whereas, Adequate HAI reporting is a key component of several federal initiatives that are in progress to advance HAI prevention, and there has been a rise in consumer advocates and public outrage over the extent of HAIs as well as a growing societal expectation for HAIs to be publicly reported;\textsuperscript{9} and

Whereas, The US Department of Health and Human Services (HHS) developed the Action Plan to Prevent Health Care-Associated Infections to assess national progress in reducing HAI rates, and this document prioritizes HAI prevention and elimination efforts at the federal, state, and local levels, along with the creation of the Federal Steering Committee for the prevention of HAIs;\textsuperscript{9, 10, 11} and

Whereas, The Office of Disease Prevention and Health Promotion (ODPHP), Division of Healthcare Quality, the Agency for Healthcare Research and Quality (AHRQ), and the CDC have worked to produce comprehensive evaluations of HHS programs related to the National Action Plan to Prevent Health Care-Associated Infections;\textsuperscript{1, 10, 11} and

Whereas, 37 US states and territories have adopted laws requiring HAI data submission, with most states requiring the reporting of central line-associated bloodstream infections in adult ICUs and about half requiring the reporting of methicillin-resistant Staphylococcus aureus and Clostridium difficile infections;\textsuperscript{12} and
Whereas, Providers, facilities, state health departments, the CDC, and the Centers for Medicare and Medicaid Services (CMS) all conduct HAI reporting to the public; and

Whereas, There is considerable diversity in how each state reports HAI data, and there are mixed data on whether public reporting reduces HAIs, which suggests that the effect of public reporting could depend on how effectively HAI information is conveyed to target audiences; and

Whereas, Some states have made substantial changes in their public reporting since they began public disclosure of HAIs, but how these changes affect the quality of information reporting has not been widely studied; and

Whereas, The legislative scope proposed by each state for public HAI reporting is varied and not standardized, and future studies could focus on whether these laws have actually reduced infection rates, given that recent studies suggest that HAI reduction efforts at the state and federal levels have not achieved their desired effects on hospital infection rates; and

Whereas, There is no agreed-upon scoring system for assessing the quality of public reports or websites for HAIs or an agreed set of best practices in assessing how public HAI reporting is conducted, with public HAI reporting left to the discretion of health agency personnel who design HAI websites and reports; and

Whereas, While different scoring criteria for assessing the quality of public HAI reporting may be deemed sensible, they may include different factors or weigh factors differently, resulting in different scores and different conclusions; and

Whereas, Public HAI reports may provide data for MRSA, CAUTI, CLABSI, and SSIs, but not an overall HAI measure, so that performances on different HAI measures are in multiple locations within the report, reducing the usability of these reports for consumers; and

Whereas, Public HAI reports may disclose a type of HAI for only a certain part of a facility or use different measures of infection rate for the same type of HAI, reducing the usability of these reports and making it difficult to assess whether infection rates are improving; and

Whereas, Some states, in their public HAI reporting, tend not to provide overall facility-level information or overall HAI measures that make it easier for consumers to assess overall facility quality; therefore be it RESOLVED, That our AMA-MSS supports the disclosure of health care-associated infection (HAI) measures that increase the quality and usability of public HAI reporting; and be it further RESOLVED, That our AMA-MSS supports a standardized manner for the quality assessment of public reporting for health care-associated infections (HAIs).

Fiscal Note: Minimal, 4

Date Received: 9/20/17

References:


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

**Blood Bank Look-Back Programs H-50.976**

Our AMA supports the concept of blood bank look-back recipient notification programs as a means of protecting patients and reducing the possible spread of infections.
Enhancing Antibiotic Stewardship in the Human Health Care Setting to Improve Patient Outcomes H-100.952

Our AMA will: (1) support antimicrobial stewardship programs, overseen by qualified physicians, as an effective way to ensure appropriate antibiotic use to reduce the burden of antimicrobial resistance, to improve patient outcomes, and to reduce overall costs for health care facilities and systems. Antibiotic stewardship programs are systematic, multi-faceted, patient safety programs, and use evidence-based approaches to optimize antibiotic prescribing, encompassing components such as policy, guidelines, surveillance, education, epidemiology, process, and outcome measurement. Successful antibiotic stewardship programs monitor and direct antimicrobial use, providing a standard, evidence-based approach to judicious antibiotic use across the spectrum of care, including, but not limited to acute care hospitals, outpatient clinics, emergency departments and long-term care facilities; (2) support the development of antibiotic stewardship programs that allow flexibility so that adherence to national requirements does not limit the ability of providers to design programs based on local variables, such as health care facility size, patient population served, and care delivery setting (e.g., outpatient v. inpatient) and to address local antimicrobial stewardship and infection prevention challenges; (3) urge each health care facility's governing body to promote and support robust, physician-led antimicrobial stewardship and infection prevention programs as critical components of assuring safe patient care; and (4) support continued research into the impact of antibiotic stewardship programs on process outcomes and encourage increased research on the impact of such programs on patient-centered outcomes.

Responsibility for Infection Control H-235.969

AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.

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

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

Health Promotion and Disease Prevention H-425.993

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

Influenza Vaccine Availability and Distribution H-440.851

Our AMA will: (1) continue efforts to communicate strongly to its partners involved in influenza vaccine production and distribution that physicians must receive influenza vaccines in a timely and equitable manner in order to help immunize all patients ≥6 months of age as recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization
Practices (ACIP); (2) urge manufacturers and distributors of influenza vaccine to provide a dedicated ordering system for small- and medium-size medical practices to pre-order vaccine up to an appropriate volume threshold; (3) support federal actions to allow physicians (MDs and DOs) to form purchasing alliances to allow for competitive purchasing of influenza vaccine comparable to large purchasers currently supplying pharmacy and grocery chain stores with influenza vaccine; (4) communicate current ACIP recommendations on the influenza vaccine to physicians and assist the CDC in disseminating its informational letters and bulletins to physicians and other providers of the influenza vaccine when they become available in order to ensure compliance with the ACIP recommendations with respect to immunization of patients with influenza vaccine; (5) work with the CDC and other immunization partners to explore options to provide for timely influenza immunization of indigent or underserved populations, including exploring options to provide for the timely redistribution of state and federally funded influenza vaccines to facilities or groups within the state willing to appropriately manage, distribute, and administer the vaccine to indigent or underserved populations; (6) continue its collaboration with the CDC and other stakeholders in influenza vaccination to work to achieve the influenza immunization goals of Healthy People 2020, with particular attention to improving demand for vaccine and achieving stability in the vaccine supply; (7) work with local public health officers through the Federation to respond to community flu vaccine shortages and possible influenza outbreaks to protect the public health; and, (8) urge the federal government to support, as a national priority, the development of safe and effective influenza vaccines employing new technologies and to continue to support adequate distribution to ensure that there will be an affordable, available and safe supply of influenza vaccine on an annual basis.

**Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856**

Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAI; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce rates of HAI and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.

**Support of a National Laboratory Network H-440.891**

Our AMA supports the efforts of the Centers for Disease Control and Prevention in establishing a national laboratory network for communicating, coordinating, and collaborating with physicians and laboratory professionals on public health concerns.

**Support for Public Health D-440.997**

1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society’s interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.
2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state
public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.

3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.

**US Public Health Service H-440.998**

In matters pertaining to the traditional responsibilities of the United States Public Health Service, the medical and related scientific decisions should remain within the purview and jurisdiction of those who are trained medical officers.

**8.11 Health Promotion and Preventive Care**

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

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

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

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

(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.

(b) Educate patients about relevant modifiable risk factors.

(c) Recommend and encourage patients to have appropriate vaccinations and screenings.

(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.

(e) Collaborate with the patient to develop recommendations that are most likely to be effective.

(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.

(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

(h) Recognize that modeling health behaviors can help patients make changes in their own lives.
Collectively, physicians should:

(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.

(j) Advocate for healthier schools, workplaces and communities.

(k) Create or promote healthier work and training environments for physicians.

(l) Advocate for community resources designed to promote health and provide access to preventive services.

(m) Support research to improve the evidence for disease prevention and health promotion.

215.001MSS Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease:
AMA-MSS will ask the AMA to advocate for the adoption of hospital guidelines for dress codes that minimize transmission of nosocomial infections, particularly in critical and intensive care units. (MSS Amended Res 6, I-08) (AMA Res 720, A-09 Referred) (Reaffirmed: GC Rep B, I-13).

440.011MSS Nosocomial Transmission of Disease via Stethoscope:
AMA-MSS will ask the AMA to advocate that health care providers frequently clean their stethoscopes and take all reasonable precautions with their other hand-held instruments in order to minimize the potential risk of nosocomial infection. (AMA Res 501, I-96 Adopted [H-440.908]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16).
Whereas, there is high prevalence of poor wellness among medical students, including increased depression and associated symptoms, increased suicidal ideations, increased stress, reduced sleep, and increased burnout\(^1\)\(^-\)\(^13\); and

Whereas, AMA policy recommends medical schools to provide access to proactive and reactive supports such as low-cost, confidential mental health and substance use disorder counseling services as well as mental health, substance abuse awareness, and suicide prevention screening programs (H-295.858); and

Whereas, Although traditional efforts on enhancing access to mental health and wellness services are important, innovative approaches to incorporate student wellness in curricula can serve as proactive support for medical student wellbeing\(^14\); and

Whereas, Our AMA recognizes the need for ongoing education of all physicians and medical students regarding physician health and wellness (AMA Code of Ethics, H-405.961); and

Whereas, Wellness education programs and workshops foster proactive wellness practices and health habits, such as stress reduction techniques and resilience-improving techniques\(^17\)\(^-\)\(^20\); and

Whereas, Resilience, the dynamic capability that allows people to thrive on challenges given appropriate social and personal contexts, is highly relevant to medical training\(^21\)\(^-\)\(^24\); and

Whereas, Resilience skills training reduces burn out, reduces depression symptoms, reduces anxiety symptoms, and reduces stress, and increases community cohesion among medical students\(^14\),\(^25\); and

Whereas, Some medical programs offer curricula that support student wellbeing through the provision of resilience-based curricular programs\(^26\)\(^-\)\(^28\); and

Whereas, curricula addressing medical student wellness fosters a critical early professional commitment to wellness during medical training in order to build a foundation of wellness practices and to avoid compromising physician health or wellness, which may impact the safety and effectiveness of the medical care provided (AMA Code of Ethics, 9.3.1); therefore be it

RESOLVED, That our AMA encourages medical schools to incorporate resilience skills training into medical school curricula.
References:


RELEVANT AMA AND AMA-MSS POLICY:

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

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

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

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

**Physician Health Programs H-405.961**
Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

**Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973**
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

**Expansion of Student Health Services H-295.872:** Already reflected in current LCME standards and (in part) now incorporated into Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians.

**Physician and Medical Student Burnout D-310.968**
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
Physician Health & Wellness 9.3.1
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. To fulfill this responsibility individually, physicians should: (a) Maintain their own health and wellness by: (i) following healthy lifestyle habits; (ii) ensuring that they have a personal physician whose objectivity is not compromised. (b) Take appropriate action when their health or wellness is compromised, including: (i) engaging in honest assessment of their ability to continue practicing safely; (ii) taking measures to mitigate the problem; (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease; (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition. Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

Resident/Fellow Work and Learning Environment 310.030MSS
The AMA-MSS will ask the AMA to supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important for patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) The Joint Commission should create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) The Joint Commission should establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; (11) The AMA Council on Legislation should serve as the coordinating body in the creation of legislative and regulatory options.

Regulation of Medical Student Education Opportunities 295.011MSS
AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (AMA Res 142, I-87 Adopted [H-295.974]) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I- 02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

Suicide Prevention Program for Medical Students 295.058MSS
AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H-345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS**

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

**Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS**

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 33
(1-17)

Introduced by: Marina Horiates, Johns Hopkins University School of Medicine; Daniel Kerekes, Johns Hopkins University School of Medicine; Region 6

Subject: Mental Health Support for Displaced Persons and Relief Workers

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

1 Whereas, The number of refugees, asylum-seekers, and internally-displaced persons worldwide has been increasing every year for the previous five years; and

2 Whereas, An average of 20 people per minute worldwide were forced to leave their homes behind in 2016; and

3 Whereas, Projected financial requirements to adequately address global refugee crises are at an all-time high; and

4 Whereas, Natural disasters that individually cause at least $1 billion in damage are increasing in frequency in the U.S., suggesting displacement will be a persistent issue in our nation; and

5 Whereas, Individuals affected by humanitarian emergencies are at increased risk for a variety of disabling mental health disorders, including PTSD, depression, anxiety disorders, substance abuse, insomnia, and dissociative symptoms; and

6 Whereas, A case study of 238 Iraqi Yazidis displaced into Turkey found that nearly 43% met criteria for PTSD, 40% for major depression, and 26% for both disorders; and

7 Whereas, Relief workers who respond to natural and man-made disasters experience PTSD and depression or depressive symptoms at three times the rate of reference groups; and

8 Whereas, Some studies of humanitarian workers report symptoms associated with high risk for depression in as much as 68% of the cohort, PTSD symptoms in as much as 42%, anxiety in up to 53%, and sleep difficulties in up to 47%; and

9 Whereas, A survey of 754 aid workers reported that 79% had experienced mental health issues; and

10 Whereas, Humanitarian workers are constantly targeted by violent attacks, and therefore are subject to increased exposure to trauma; and

11 Whereas, Effective mental health solutions to help address the psychological needs of refugees and relief workers have been outlined; and

12 Whereas, Current health system responses to mental illness in conflict-affected regions are considered largely inadequate; and
Whereas, The United Nations High Commissioner on Refugees reported in 2013 that the UN only followed 35% of the recommended international guidelines to provide psychological support to its aid workers, a level of adherence typical of other aid organizations;¹⁰,¹¹ and

Whereas, Efforts to promote delivery of equitable health care to diverse patient populations are a major focus of current health policy;²⁰ and

Whereas, The AMA and our AMA-MSS recognize the importance of detecting and treating mental illness in physicians, residents, medical students, patients, university students, and public school students (D-345.994; 295.137MSS; 295.164MSS; 310.054MSS; 345.002MSS; 345.009MSS; 345.011MSS; MSS Res 49, A-15); and

Whereas, The AMA and our AMA-MSS recognize the unique health needs of refugees (H-350.956, H-350.957, 250.020MSS, 250.028MSS), but neither have policy regarding aid workers; and

Whereas, The AMA and our AMA-MSS have policies to provide “food, medicine and medical equipment” to disaster-afflicted areas (H-65.994; MSS Res 24, I-10), but not to provide psychological support to either refugees or aid workers; therefore be it

RESOLVED, That our AMA encourage aid organizations to rigorously assess the effectiveness of their mental health systems already in place; and be it further

RESOLVED, That our AMA work with aid organizations, including the United States federal government, to support the universal adoption of basic standards for mental health support of displaced persons and humanitarian aid workers.

Fiscal note: Significant, 12

References:


**Relevant AMA and MSS Policy:**

**Medical Care in Countries in Turmoil H-65.994**

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country’s government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education
and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

**Increasing Detection of Mental Illness and Encouraging Education D-345.994**

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

**Increasing Access to Healthcare Insurance for Refugee Populations H-350.956**

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

**Addressing Immigrant Health Disparities H-350.957**

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

**Refugee Health Care 250.020MSS**

AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (MSS Amended Res 4, A-09) (AMA Res 804, I-09 [H-350.957]) (Modified and Reaffirmed: MSS GC Rep A, I-14)

**Increasing Access to Healthcare Insurance for Refugees 250.028MSS**

AMA-MSS will ask that our AMA support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees. (MSS Res 05, I-16) (AMA Res 006, A-17 Adopted )

**Expansion of Student Health Services 295.137MSS**

AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage. (MSS Rep D, I-05, AMA Res 309, A-06, Referred) (CME Rep 6, A-07 Adopted [H- 295.956]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep D, I-15)

**Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS**

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

**Preventing Resident Physician Suicide 310.054MSS**
AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

**An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses 345.002MSS**
AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students. (MSS Sub Res 22, I-05 Adopted in Lieu of Res 12 and 13) (AMA Amended Res 412, A-06 Adopted [H-345.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS**
AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)

**Improving Mental Health at Colleges and Universities for Undergraduates 345.011MSS**
AMA-MSS will ask (1) that our AMA support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; (2) that our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and (3) that our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. (MSS Res 30, A-16)

**Supporting the Incorporation of Community-Based Early Detection, Treatment, and Prevention of Psychosis into Mental Health Systems MSS Res 49, A-15**
The MSS formally establishes support for the following HOD policy: D-345.994 Increasing Detection of Mental Illness and Encouraging Education 1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers 2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12)
AMA Support of Medical Supply Reuse Programs MSS Res 24, I-10

The MSS formally establishes support for the following HOD policies:

D-250.992 Medical Supply Donations to Foreign Countries

Our AMA will: (1) continue to advertise opportunities for donations on the AMA web site and continue to refer individual physicians to appropriate relief agencies; and (2) continue current relationships with relief organizations.

H-65.994 Medical Care in Countries in Turmoil The AMA

(1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

H-250.987 Duty-Free Medical Equipment and Supplies Donated to Foreign Countries

Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries.
Whereas, Congress passed the Orphan Drug Act (ODA) of 1983 in response to declining pharmaceutical investment of “orphaned” drugs through clinical trials following the Kefauver-Harris amendments of 1962 because of increased development costs; and

Whereas, The “orphan” designation is intended for drugs that target rare conditions affecting fewer than 200,000 Americans, and are thus often deemed “unprofitable” due to the difficulty of recuperating development and marketing costs; and

Whereas, To promote the research of therapies against rare diseases and conditions, the ODA offers a variety of incentives, including 1) 7 years of market exclusivity, 2) a tax credit up to 50% of clinical trial costs, 3) direct federal grants to the pharmaceutical company up $500,000 per year for 4 years, and 4) a waiver of marketing user application fees; and

Whereas, Although the ODA has been credited for introducing over 400 orphan drugs since becoming law, physicians, researchers, and policymakers have raised concerns about potential abuses of the Act; and

Whereas, Though the Act’s original intent was to incentivize the development of “non-profitable” therapies treating fewer than 200,000 Americans, several drugs have obtained “blockbuster” status indicating >$1 billion in sales annually, sometimes through a multitude of loopholes; and

Whereas, One such loophole is the approval for “orphan designation” - and therefore, ODA benefits - of existing compounds and mass-market drugs, as is the case for 3,4-DAP, ascorbic acid, calcium carbonate, Humira, and Crestor; and

Whereas, A pharmaceutical company may strategically submit a drug for approval of a single
indication - “one that is narrow enough to qualify for orphan drug benefits” - and once approved, the drug is utilized for a variety of off-label uses, as demonstrated by the drugs rituximab, modafinil, and a variety of oncology drugs;¹⁰,¹⁵,¹⁶ and

Whereas, A pharmaceutical company may strategically apply for additional approval for new indications, as has been demonstrated by rituximab, imatinib, and epoetin-alfa;⁹,¹⁷,¹⁸ and

Whereas, The ODA’s 7-year marketing exclusivity benefit may extend beyond the trademark office patent, and can “run concurrently or sequentially on the basis of number of indications for the drug, effectively providing pharmaceutical companies with government-sponsored monopolies”;⁹,¹⁹ and

Whereas, Pharmaceuticals designated as “Orphan Drugs” receive further legislative protection including exclusion from the drug discount program of the Public Health Service Act;¹¹ and

Whereas, Although each individual indication of an orphan drug at the time of FDA approval must treat fewer than 200,000 Americans, the cumulative indications for a drug can result in treating a larger population;¹² and

Whereas, The exploitation of these and other potential loopholes within the Act have resulted in both exorbitant price hikes and increasing sales, contributing up to one-fifth of global prescription sales by 2020 despite the original purpose of treating small populations;¹³,¹⁹,²¹ and

Whereas, multiple pieces of legislation pertaining to the Orphan Drug Act have been submitted by both parties in the 115th Congress, which along with recent action by the FDA, indicates legislative and regulatory awareness of improvements that can be made and a will to do so;²⁰,²³-²⁵ and

Whereas, The AMA-MSS’s existing policy on the Orphan Drug Act was forwarded to the AMA HOD in 1990, 27 years ago, and the AMA has yet to adopt policies concerning the ODA; and

Whereas, The AMA supports efforts to reduce the cost of pharmaceuticals and encourages transparency in drug pricing (H-110.987, H-110.997, H-110.998); and

Whereas, The AMA encourages open dialogue among researchers, industry, and clinicians on the financial impact of new therapies and their efficacy (H-460.965); therefore, let it be

RESOLVED, That our AMA support legislation and policy efforts to reform the Orphan Drug Act by closing loopholes identified by the FDA in order to protect the Act’s original intent of promoting therapies targeting rare diseases; and be it further

RESOLVED, That our AMA support increased transparency in development costs, post-approval regulation, overall earnings, and off-label uses for pharmaceuticals designated as “Orphan Drugs”; and be it further
RESOLVED, That our AMA support efforts to modify the exclusivity period of “Orphan Drugs” in order to increase access to these pharmaceutical drugs.

Fiscal Note: Moderate, 10

Date Received: 9/20/17

References:

RELEVANTAMA AND AMA-MSS POLICY:

Pharmaceutical Cost H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

**Cost of New Prescription Drugs H-110.998**

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

**Viability of Clinical Research Coverages and Reimbursement H-460.965**

Our AMA believes that:

(1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;

(2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;

(3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;

(4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;

(5) its current efforts to identify unproven or fraudulent technologies should be enhanced;

(6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;

(7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
(8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;

(9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well being of the American people;

(10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and

(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles and otherwise not covered clinical care in the context of nationally approved clinical trials.

100.002MSS Opposition to Abuses of the Orphan Drug Act

100.014MSS Drug Pricing Reform
AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies. (MSS Res 21, I-15)
Whereas, the active component of the Armed Forces is now 14% female and the reserve component is 18% female who, as female veterans transition into veteran status, are now making up the fastest growing cohort within the veteran community; and

Whereas, by 2020, women will comprise nearly 11% of the total veteran population; and

Whereas, over the last decade alone, the number of women veterans using Veteran Affairs (VA) health care has nearly doubled; and

Whereas, the National Survey of Women Veterans reports that about 40% of women veterans who served in the recent conflicts in Iraq and Afghanistan incorrectly believe that only those with service-connected disability are eligible for VA health care; and

Whereas, a 2014 membership survey of Iraq and Afghanistan Veterans of America (IAVA) found that only 58% of women veterans reported being contacted by the Veteran’s Affairs health care or seeing VA advertisements about women’s eligibility for VA services and benefits; and

Whereas, cross-sectional analysis of data provided by 286 female veterans of Operation Iraqi Freedom and/or Operation Enduring Freedom found that 76% of women veterans who were prescribed drugs by VA health care providers had not been warned about risks of medication-induced birth defects; and

Whereas, the Study of Barriers for Women Veterans to VA Health Care Final Report published by the VA found that 19% of women veterans who utilize VA health care services reported avoiding the VA because of past sexual trauma, citing the historically male dominated culture and patient base in VA facilities as a factor; and

Whereas, only 30% of facilities provided Substance Use Disorder (SUD) women specific groups, and only 14% provided women specific SUD-Posttraumatic Stress Disorder groups; and
Whereas, women veterans with a history of military sexual assault and/or posttraumatic stress symptomatology perceive that they are not receiving the same quality of care as male veterans\textsuperscript{4,8}; and

Whereas, AMA policy (H-510.984) supports comprehensive health care services to provide treatment within the standard of care to address infertility due to service-related injuries and preserve a veteran’s ability to conceive a child; however, only 58\% of sites offer gynecological services and, of those, only 25\% offer infertility treatment\textsuperscript{9,10}; and

Whereas, in a study of women veterans who reported using the VA system, 72\% indicate that they do not utilize the nearest VA facility for primary care, with the most common reason being “the women’s services I need are not available [at the facility]\textsuperscript{11},” therefore be it

RESOLVED, that our AMA advocate for further study to identify the specific healthcare needs of the growing population of women veterans, and be it further

RESOLVED, that our AMA supports measures to improve women veteran’s access to care.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:

2. Friedman SA, Phibbs CS, Schmitt SK, Hayes PM, Herrera L, Frayne SM, New Women Veterans in the VHA: A Longitudinal Profile, Womens Health Issues. 2011


RELEVANT AMA AND AMA-MSS POLICY:

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation’s veterans.

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration

Expansion of US Veterans’ Health Care Choices H-510.983
1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide
adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.

AMA MSS Policies
520.005MSS Ensuring High Quality Care for All Veterans and Their Families: Our AMA-MSS supports all avenues available to guarantee access to high quality health care for all eligible veterans and their families. (MSS Res 19, I-15)
Whereas, Approximately 16.9% of children and adolescents aged 2–19 years in the United States are obese, the majority of whom are low-income;¹,² and

Whereas, In Western countries, up to 30% of pregnant women are obese, and approximately 40% of women gain an excessive amount of weight during pregnancy;³ and

Whereas, Gestational weight gain (GWG) exceeding recommendations made by the National Academy of Medicine is associated with greater offspring BMI, increased odds of childhood overweight and obesity, and increased lifetime risk for cardiovascular and metabolic conditions, independent of several potential confounders and mediators;³,⁴,⁵,⁶,⁷,⁸,⁹ and

Whereas, Even infants determined to be of a healthy birth weight born to overweight mothers have an increased tendency towards obesity throughout childhood;¹⁰ and

Whereas, Identification of risk factors for childhood obesity is critical in combatting this public health crisis and mitigating subsequent risk of type 2 diabetes, cardiovascular disease, and long-term risk for other serious chronic conditions;⁵ and

Whereas, A high level of disparity exists in racial and ethnic minority populations surrounding gestational weight gain, an inequity requiring further research and intervention;¹¹,¹² and

Whereas, Several organizations (Centers for Disease Control, World Health Organization, National Academy of Medicine, American Academy of Pediatrics) have published revised guidelines for gestational weight gain based on pre-gravid BMI and appropriate infant weight gain, which have not been widely implemented in provider offices nor in WIC program-sponsored prenatal counseling;¹⁰

Whereas, A factor in the lack of implementation is inadequacy of prenatal weight and nutrition counseling;¹⁰ and
Where, The inadequacy of prenatal weight management and nutrition counseling may be affected by providers’ own negative perceptions of their ability to influence their patients’ habits through weight management discussions; \(^{12}\) and

Whereas, Pregnancy is a period during which women are at high risk for transitioning from normal weight to overweight or even obesity, making prenatal care appointments a crucial time to discuss weight management strategies; \(^{10,12}\) therefore be it

RESOLVED, That our AMA encourage stakeholders to develop interventions to facilitate widespread implementation of and adherence to published guidelines for appropriate weight gain during pregnancy; and be it further

RESOLVED, That our AMA encourage the study of effective and affordable interventions to assist providers and women in managing weight gain during pregnancy, as well as research to evaluate the efficacy of those interventions amongst high risk populations, including low-income and minority populations.

Fiscal Note: Significant, 10

Date Received: 9/20/17

References:


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

**Nutrition Education for Parents of School Aged Children 170.012MSS**

AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to educate parents about healthy lifestyles in an effort to prevent and reduce the prevalence of overweight and obesity in children and adolescents. (MSS Res 7, A-06) (Reaffirmed: MSS Res 46, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**Childhood Obesity as a Public Health Epidemic 440.018MSS**

AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

**Obesity as a Chronic Disease 440.013MSS**

AMA-MSS will ask the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence-based recommendations regarding education, prevention, and treatment of obesity. (MSS Amended Sub Res 33, A-98) (AMA Amended Res 423, A-98 Adopted [H-440.902]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

**Obesity as a Major Health Concern H-440.902**

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

Prenatal Services to Prevent Low Birthweight Infants H-420.972
Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants.

Preconception Care H-425.976
1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state: (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan; (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts; (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes; (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact); (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth); (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy; (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and interconception care; (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes; (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman’s reproductive health.

Obesity as a Major Public Health Program H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated AMA-MSS Digest of Policy Actions/ 161 with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of
overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

Infant Mortality D-245.994
1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.

2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 37
(I-17)

Introduced by: Region 1; Region 2; Region 3; Julie Lin, Northeast Ohio Medical University;
Pauline Huynh, Johns Hopkins University School of Medicine;

Subject: Machine Intelligence in Healthcare

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Artificial intelligence is a general cultural and technical term for entities created by
humans on any substrate - biological, mechanical, or otherwise - that exhibit intelligent behavior
not dependent on naturally occurring brain architectures;1 and

Whereas, Machine intelligence is a subset of artificial intelligence that is computed on
mechanical substrates using techniques like machine learning that allow software applications
to become more accurate in predicting outcomes;2 and

Whereas, Machine learning algorithms have been developed for diagnostic evaluation and
outcome prediction of several diseases;3-6 and

Whereas, Machine intelligence is expected to become an integral part of health care;7-10 and

Whereas, There are considerable logistical and ethical concerns surrounding the application of
machine intelligence in healthcare settings;1,10,11 therefore be it

RESOLVED, That our AMA-MSS supports the use of machine intelligence as a complementary
tool in making clinical decisions; and be it further

RESOLVED, That our AMA-MSS supports ethical, rapid development and deployment of
machine intelligence research and machine learning techniques to improve clinical decision-
making, including diagnosis, patient care, and health systems management; and be it further

RESOLVED, That our AMA-MSS supports partnerships with organizations actively developing
machine intelligence and other appropriate groups to evaluate clinical outcomes, develop
regulatory guidelines for the use of machine intelligence in healthcare, and ensure further
developments will be beneficial to patients, physicians, and society; and be it further

RESOLVED, That our AMA-MSS encourages the education of medical students and physicians
on the use of machine intelligence in healthcare; and be it further

RESOLVED, That our AMA-MSS supports increased utilization of the term "machine
intelligence" rather than the term "artificial intelligence" when considering the use of computers
to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making.

Fiscal Note: Minimal, 6

Date Received: 9/20/17
References:


RELEVANT AMA AND AMA-MSS POLICY:

Clinical Algorithm Impact on Patient Care H-410.971
The AMA has established the following policy that incorporates provisions regarding the use and development of clinical algorithms, which may include the following: (1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use his or her best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly. (2) Clinical algorithms should include suggested tests and procedures to arrive at a correct diagnosis in the most direct and expeditious manner. These guidelines should suggest criteria as to when referrals to the correct specialist/subspecialist are appropriate and in the best interest of the patient. (3) The treating physicians should always have the option of ordering the suggested tests, procedures and referrals at their discretion, and may opt to make these choices earlier or later than is suggested, and is not mandated to make any of these choices, depending on their clinical assessment of the patient and their needs. (4) When the
algorithms are created, physicians from the specialty(ies)/subspecialty(ies) who diagnose and
treat the condition should participate in their creation. These physicians should be
representatives from their official specialty society(ies). (5) The validity of any clinical algorithms
should be under constant review and evaluation by the appropriate specialty/subspecialty
society(ies). (6) Whenever possible consensus clinical data from peer review journals will be
used.

**National Agency for Technology Evaluations H-480.954**
Our AMA advocates for active AMA input into any national agency whose role would be to
evaluate technology for its value, to assist Medicare and other payors in making appropriate
coverage decisions.

**Technology and the Practice of Medicine G-615.035**
Our AMA encourages the collaboration of existing AMA Councils and working groups on
matters of new and developing technology, particularly electronic medical records (EMR) and
telemedicine.

**Medical Technology Assessment 480.001MSS**
AMA-MSS supports the following principles: (1) Medical technology assessment should include
societal, economic, ethical, and legal consequences of medical technologies, as well as
concerns of safety and efficacy. (2) The medical community should stress the use of
randomized, controlled clinical trials when ethical prior to the wide spread dissemination of
medical technologies and emphasize the importance of clinical trials to health professionals. (3)
Medical technologies should not be accepted as standard medical practice before they have
been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal
consequences. (4) Organized medicine should continue its involvement with the Prospective
Payment Assessment Commission, and should actively lobby for funding which would allow this
body to accomplish its mandate with regard to medical technology evaluation. (5) Organized
medicine should support the creation of a private/public sector consortium, as defined by the
Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse
for the evaluation of medical technologies. (6) Organized medicine should seek active
representation in such a private/public sector consortium, and should research possible sources
of funding (e.g., government, third party payers, technology producers). (7) Organized medicine
should work to assure a mechanism for awarding competitive grants to fund high quality clinical
trials for the assessment of medical technology.
Whereas, Affirmative action is a race-conscious recruitment policy designed to equalize access to jobs and professions such as medicine and based on the premise that relief from illegal racial discrimination is not enough to remove the burden of second-class citizenship from underrepresented minority groups;¹ and

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

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

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

Whereas, Underrepresented minority physicians are more likely to practice in underserved areas and tend to serve populations with higher percentages of medically indigent patients;⁷,⁸,⁹ and

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

Whereas, Several states that have instituted bans on affirmative action have experienced subsequent decreases in college enrollment by minority students, completion of STEM degrees by minority students, and representation of minority students among matriculating medical school students;¹²,¹¹ and

Whereas, In 1978, 2003, and 2016 the supreme court upheld affirmative action in the cases of Regents of the University of California v. Bakke, Grutter v. Bollinger, and Fisher v. The University of Texas at Austin, respectively, allowing race to be one of several factors in college admission policy;¹³,¹⁴,¹⁵ and

Whereas, Although AMA policy establishes a significant precedent to support undergraduate education as a means to produce medical school matriculants (H-60.917, H-350.979,H-200.985), existing policy falls short of addressing the necessity of affirmative action as a mechanism for equality at the undergraduate level, which is necessary to bolster the pool of minority students able to apply to a medical program; and
Whereas, The Department of Justice has announced the intent to investigate and potentially sue institutions utilizing affirmative action, threatening the principles of racial equality in education that our AMA supports; therefore be it

RESOLVED, That our AMA amend H-350.979 by addition,

“(3) Urging medical school and undergraduate admission committees to consider minority representation as one factor in reaching their decisions.”; and be it further

RESOLVED, That our AMA oppose legislation that would dissolve affirmative action or punish institutions for properly employing affirmative action to promote a diverse student population; and be it further

RESOLVED, That our AMA-MSS reaffirm 350.011MSS Continued Support for Diversity in Medical Education and 350.003MSS Minority Representation in the Medical Profession.

Fiscal Note:

Date Received: 9/20/17

References:

5. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. BMC Medical Education. 2003;3(1).
10. Lakhan SE. Diversification of U.S. medical schools via affirmative action implementation. BMC Medical Education. 2003;3(1).

RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

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

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

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
Minority and Disadvantaged Medical Student Recruitment and Retention Programs 350.001MSS
AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose economically disadvantaged students to the career of medicine; special summer programs to bring minority and economically disadvantaged students to medical schools for an intensive exposure to medicine; and conduct retention programs for minority and economically disadvantaged medical students who may need assistance. (AMA Res 35, I-79, Referred) (CME Rep T, I-79, 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 Res 4, I-14)

Minority Representation in the Medical Profession 350.003MSS
AMA-MSS will ask the AMA to: (1) support Affirmative Action in recruitment, retention, and graduation of minorities by all medical schools; and (2) urge private sources and federal and state governments to ensure sufficient funding to support increases in minority and economically disadvantaged student representation in medical schools.

Funding for Affirmative Action Programs 350.004MSS
AMA-MSS will ask the AMA to: (1) support counseling and intervention designed to increase minority enrollment, retention, and graduation of medical students; and (2) support increased funding appropriations to DHHS Health Careers Opportunities Program.

Continued Support for Diversity in Medical Education 350.011MSS
AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training. (MSS Res 3, A-03) (AMA Res 325, A-03, Adopted [295.963]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

Youth Health Pipeline Programs Initiative 350.014MSS
AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with local medical societies to develop pipeline programs that increase underrepresented in medicine (UIM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical school AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students. (MSS Res 27, I-15)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 39
(I-17)

Introduced by: Lucy Ching Chau Wayne State, University School of Medicine; Shannon Paquette, Wayne State University School of Medicine; Anna Heffron, University of Wisconsin School of Medicine and Public Health; Ryan Denu, University of Wisconsin School of Medicine and Public Health; David Goldrich, Robert Wood Johnson Medical School

Subject: Establishing Tax Benefits for Living Organ Donors

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, The national rate of living organ transplantation has been decreasing annually since 2005; and

Whereas, Studies have shown that direct costs to living organ donors, including lost employment, travel, and uncovered medical costs average approximately $5000, which is greater than one month’s wage for 76% of donors and financial burdens for living kidney donors have been shown to increase risk of depression and lower risk of life satisfaction after surgery; and

Whereas, Living kidney donors report 252 hours of lost work and over 25% have insufficient medical leave/vacation for the recommended 4 to 6 weeks of recovery while federal employee organ donors receive 30 days paid leave beyond ordinary sick/annual leave (5 U.S.C. 6327); and

Whereas, Approximately 30% of living organ donors are persons of ethnic minorities who have been shown to be at greater risk of financial impacts both pre- and post-donation; and

Whereas, Policies increasing donor benefit have successfully increased rates of living organ donation in a number of countries and studies have shown that medical professionals, current living kidney donors, and the general public consider many methods of financial incentives for organ donation acceptable; and

Whereas, $12 billion of taxpayer funds are spent annually on dialysis for individuals with end stage renal disease and an estimated $150,000 taxpayer dollars are saved per transplant per year; and

Whereas, The estimated threshold to motivate the donation of a solid organ has been suggested to be $10,000 worth of financial incentives; and

Whereas, Amendment of New York Tax law § 612 c(38) in 2006 to allow up to $10,000 lifetime tax deduction for living organ donors has been suggested to increase living unrelated kidney donation rates by 52% and state legislation for paid or unpaid employment leave as well as tax benefits for living organ donation has been suggested to significantly increase the rates of living unrelated kidney donation; and
Whereas, Although some studies found no effect of tax benefits on overall living organ donation rates, they did not investigate their relationship to the rate of living unrelated organ donation alone and there is ongoing debate as to the appropriateness of the model used in those studies.21-23 and

Whereas, The National Organ Transplant Act (NOTA) prohibits the acquisition of human organs in exchange for "valuable considerations" or payments but explicitly allows "reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ";24 and

Whereas, The Chicago Transplant Ethics Consortium (CTEC) laid out the ethical arguments in favor of investigating financial incentives for living organ donation and challenged perceptions against incentives, including concerns of commodification of the human body, damage to the physician-patient relationship, or exploitation of those of lower socioeconomic status,25 and

Whereas, The American Society of Transplantation (AST) and the American Society of Transplant Surgeons (ASTS) held a joint workshop on Increasing Organ Donation in the United States, which concluded that: "...we should be working together along the arc of change to remove remaining disincentives as well as explore opportunities to either change or modify the National Organ Transplant Act...",26 and

Whereas, Only 17 of 52 states have tax benefits for the purposes of living organ donation, and there are no existing federal tax benefits for living organ donors;27 therefore be it

RESOLVED, That our AMA support legislation expanding state and federal tax incentives for living organ donors to cover expenses incurred pursuant to donation.

Fiscal Note: Minimal, 5

Date Received:

References:


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

**H-370.958 Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool**

1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.

2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.

3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.

(Res. 7, I-15)

**H-370.965 Removing Financial Barriers to Living Organ Donation**

Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage. (BOT Rep. 15, A-12)

**H-370.974 Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors**

The AMA supports efforts to increase the number of all potential bone marrow donors registered in national bone marrow registries, especially minority donors, to improve the odds of successful HLA matching and bone marrow transplantation. (Res. 501, I-94, Reaffirmed A-04, A-14)

**H-370.996 Organ Donor Recruitment**

Our AMA
(1) continues to urge Americans to sign donor cards;  
(2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular;  
(3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card.; and  
(4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation.

H-370.959 Methods to Increase the US Organ Donor Pool

In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues.

370.015MSS Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool

AMA-MSS will ask (1) that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation, (2) that our AMA support well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (MSS Res 08, I-15 Immediate Transmittal to HOD) (AMA Res 007, I-15 Adopted)

370.003MSS Organ Donors and Transplants

AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public’s understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 40
(I-17)

Introduced by: Region 1; Brad Zehr, Boston University School of Medicine; Ajeet Singh, Loyola Stritch School of Medicine; Eric Xie, Johns Hopkins School of Medicine; Daniel Adam, Creighton University School of Medicine; Celeste Peay, Boston University School of Medicine; Luis Seija, Texas A&M College of Medicine; Rohan Rastogi, Boston University School of Medicine; Jennifer Nordhauser, Long School of Medicine at UT Heath San Antonio

Subject: Normalizing the AMA Position on Single-Payer Health Care Reform

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Current AMA policy H-165.847 establishes that comprehensive health system reform achieving quality healthcare for all Americans is of the highest priority of our AMA; and

Whereas, Our AMA is limited in its ability to engage in open and honest debate about all health care reform options via its blanket opposition of single payer financing mechanisms (AMA policy H-165.838); and

Whereas, Evidence suggests that our AMA’s stance on single payer does not currently represent the majority of physicians, with two recent surveys by the Merritt Hawkins and the Chicago Medical Society each reporting a majority of physicians either strongly or somewhat supporting the concept of a broadly labeled single payer health care system; and

Whereas, Several US senators have recently supported legislation to move forward with a national single-payer health care financing reform, and as such our AMA must be equipped to have open, productive discussions on the matter in the coming years; and

Whereas, H.R. 676 - Expanded & Improved Medicare For All Act, has 117 cosponsors, and as such will likely come to the AMA for debate in the near future; therefore be it

RESOLVED, That our AMA rescind HOD policy H-165.844; and be it further

RESOLVED, That our AMA rescind HOD policy H-165.985; and be it further

RESOLVED, That our AMA amend by deletion HOD policy H-165.888 as follows:

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

A. Physician’s maintain primary ethical responsibility to advocate for their patients’ interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

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

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan’s policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

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

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

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

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

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

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

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

RESOLVED, That our AMA amend by deletion HOD policy H-165.838 as follows:
1. Our American Medical Association is committed to working with Congress, the
Administration, and other stakeholders to achieve enactment of health system reforms that
include the following seven critical components of AMA policy:
   a. Health insurance coverage for all Americans
   b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for
      pre-existing conditions or due to arbitrary caps
   c. Assurance that health care decisions will remain in the hands of patients and their physicians,
      not insurance companies or government officials
   d. Investments and incentives for quality improvement and prevention and wellness initiatives
   e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten
      seniors’ access to care
   f. Implementation of medical liability reforms to reduce the cost of defensive medicine
   g. Streamline and standardize insurance claims processing requirements to eliminate
      unnecessary costs and administrative burdens

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

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

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

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

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

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

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the
   following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that
      widespread operational problems still have not been corrected by the Centers for Medicare and
      Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy
      situation for physicians who are already subject to an expenditure target and potential payment
      reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

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

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

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

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

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

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

Fiscal note: Minimal, 5

Date received:

References:


Relevant AMA and MSS Policy:

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

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

National Healthcare Finance Reform: Single Payer Solution 165.020MSS

(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS. (MSS Res 12, A-17)

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
   B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
   C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
   D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
   E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
   F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
   G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
   H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

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

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

**Achieving Health Care Coverage for All D-165.974**

Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.

**Educating the American People About Health System Reform H-165.844**

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

**Opposition to Nationalized Health Care H-165.985**

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

(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing
providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
   a. Health insurance coverage for all Americans
   b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
   c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
   d. Investments and incentives for quality improvement and prevention and wellness initiatives
   e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care
   f. Implementation of medical liability reforms to reduce the cost of defensive medicine
   g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

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

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

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

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

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

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

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

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

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

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

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

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

**Universal Health Coverage H-165.904**

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

**Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care D-165.935**

1. Our AMA will: (a) actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA's extensive body of policy on health system reform; and (b) craft a strong public statement for immediate and broad release, articulating the priorities and firm
commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients.

2. Our AMA Board of Trustees will report back to our AMA House of Delegates at the 2017 Annual Meeting.

**Individual Health Insurance H-165.920**

Our AMA:

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

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

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
   (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
   (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
   (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
   (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

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

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

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

**Preferred Provider Organizations H-415.999**

The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed
responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems.

**Reform the Medicare System D-330.924**

Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), defined contribution (D-330.937), and balance billing (D-380.996, H-385.991, D-390.969).

**Increasing Detection of Mental Illness and Encouraging Education D-345.994**

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health 5 departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res 412, A-06; Appended: Res 907, I-12
Whereas, The Healthy People 2020 Campaign has identified telehealth/telemedicine as an emerging trend in healthcare;¹ and

Whereas, Telehealth has demonstrated improvements in outcomes such as mortality, quality of life, and reductions in hospital admissions;² and

Whereas, A variety of medical fields have utilized telehealth ranging from dermatology and psychiatry to surgical subspecialties;³,⁴,⁵,⁶ and

Whereas, Rural family practitioners (FP) were twice as likely to use telehealth as urban FPs (22% vs. 10%)⁷ suggesting a possible avenue for improved access to care; and

Whereas, Although highly variable in nature, 24 states have policies regarding reimbursement for telehealth and 47 states have Medicaid reimbursement policies;⁸ and

Whereas, Telehealth reimbursement for evaluation and management of established patients with low complexity is 30% lower than corresponding non-telehealth services, resulting in lower incentives to implement telehealth despite the potential to improve patient outcomes;⁹ and

Whereas, The AMA has established significant ethical guidelines (Code of Ethics 1.2.12) for telehealth/telemedicine; and

Whereas, Lack of education about the technical side of telehealth (documentation, system security, and technology) and the patient side (establishing patient trust virtually, appropriate identification) has been cited as a limiting factor for telehealth;¹⁰ and

Whereas, Licensure falls under the authority of the states, thereby limiting the ability of telehealth;¹⁰,¹¹ and
Whereas, At least nine states have a special license related to telehealth allowing health care providers to provide services remotely across state lines, provided that certain conditions are met, or other forms of reciprocity or interstate compacts have been established,¹¹,¹² and

Whereas, Organizations such as the National Stroke Association have endorsed interstate medical licensure;¹³ and

Whereas, It is estimated that the cost of additional state licenses for physicians is $300 million/year;¹⁴ therefore be it

RESOLVED, That our AMA-MSS rescind policy 480.010MSS (Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician Patient Relationship); and be it further

RESOLVED, That our AMA-MSS formally support AMA policy D-295.313 (Telemedicine in Medical Education) and AMA policy H-480.974 (Evolving Impact of Telemedicine); and be it further

RESOLVED, That our AMA-MSS support the use of telehealth/telemedicine in accordance with the AMA Code of Ethics; and be it further

RESOLVED, That our AMA-MSS support reimbursement for telehealth/telemedicine to compensate for training, time, skills, and required resources; and be it further

RESOLVED, That our AMA-MSS supports continued efforts for establishing best practice to enable the interstate practice of medicine.
References:
RELEVANT AMA AND AMA-MSS POLICY:

345.013MSS Studying the Effectiveness of Telemental Health in Schools
AMA-MSS supports research by appropriate stakeholders assessing the effectiveness of telemental health programs in comparison to standard mental health services offered by elementary, middle, and secondary educational institutions. (MSS Res 20, I-16)

480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician Patient Relationship
AMA-MSS (1) supports our AMA urging the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and (2) supports our AMA seeking regulatory guidance from the DHHS regarding the essential requirements of web based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services. (Sub Res 13, A-12)

290.002MSS Interstate Medicaid Cooperation
AMA-MSS will ask the AMA to (1) support and advocate for legislation allowing out-of-state providers in close proximity to the border to be enrolled as in-state providers in those states that do not currently allow it, using Oregon’s Medicaid system as a model; and (2) support and advocate for legislation that would streamline the provider enrollment process in order to encourage more physicians to become providers for border communities. (MSS Res 28, I-10) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 113, A-11) (Reaffirmed: MSS GC Report A, I-16)

480.014MSS Support of Interstate Medical Licensure Compacts
AMA-MSS support the development and adoption by states of interstate medical licensure compacts or uniform acts to enhance medical license portability. (MSS Sub Res 15, I-14)

Code of Ethics 1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another. Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians’ fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians. All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles. Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient’s site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
   (i) establishing the patient’s identity;
   (ii) confirming that telehealth/telemedicine services are appropriate for that patient’s individual situation and medical needs;
   (iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
   (iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients’ preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient’s primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

Collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.

**Professionalism in Telemedicine and Telehealth D-480.974**

The Council on Ethical and Judicial Affairs will review Opinions relating to telemedicine/telehealth and update the Code of Medical Ethics as appropriate.

**Coverage of and Payment for Telemedicine H-480.946**

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
   a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
      - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
      - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
      - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
   Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
   b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
   c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
   d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
   e) The delivery of telemedicine services must be consistent with state scope of practice laws.
   f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
   g) The standards and scope of telemedicine services should be consistent with related in-person services.
   h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
   i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
   j) The patient's medical history must be collected as part of the provision of any telemedicine service.
   k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

**Telemedicine in Medical Education D-295.313**
1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations.
2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other healthcare professionals.
3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training.

**Evolving Impact of Telemedicine H-480.974**
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Creation of AMA Data Bank on Interstate Practice of Medicine D-275.996
Our AMA will: (1) continue to study interstate practice of medicine issues as they relate to the quality of care available to patients; (2) explore the provision of information on physician licensure, including telemedicine, to members and others through the World Wide Web and other media; and (3) continue to make information on state legal parameters on the practice of medicine, including telemedicine, available for members and others.

Facilitating Credentialing for State Licensure D-275.994
Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 42
(I-17)

Introduced by: Aradhana Verma and Roger Rothenberg, California Northstate University College of Medicine; Kshma Kulkarni, Touro University California College of Osteopathic Medicine; Adam Roussas, The University of Arizona College of Medicine - Tucson

Subject: Medical Respite Care for Homeless Adults

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, the AMA recognizes that the growing crisis of poverty, homelessness, and decreased number of mental health facilities has led to increasingly more Medicaid patients visiting the Emergency Department for preventable and predictable conditions (H-160.903, Resolution 114-A-10), and

Whereas, current healthcare delivery to homeless patients — due to higher rates of emergency department use and hospitalization compared with patients with stable housing — contributes to poor health outcomes, increased healthcare spending, and increased medical provider frustration, and

Whereas, Without a formalized post-hospitalization arrangement for homeless patients, a de facto process of care has emerged that leads to suboptimal discharge arrangements, provider burn-out, poor patient outcomes, and an overall increase in cost of patient care; and

Whereas, Medical Respite Care (MRC) is acute and post-acute medical care for homeless patients who are too sick to recover on the streets but not sick enough to be kept inpatient; and

Whereas, Medical respite centers are third-party organisations that provide homeless patients MRC, including access to nursing care, behavioral health services, substance abuse services, case managers, and primary care providers; and

Whereas, MRC is associated with fewer hospital re-admissions, and a reduction in the total amount of time patients spend in the hospital across multiple parameters as compared to patients who were unable to access MRC care; and

Whereas, MRC report overall cost-savings, particularly when compared with the cost of hospitalization, with demonstrated cost avoidance for hospitals ranging from $3.5 to $5.5 million annually; and

Whereas, As stated in the Standards for Medical Respite Care, MRC quality standards only require self-audits and do not promote standardization across facilities; and
Whereas, Because the vast majority of medical respite centers do not receive funding from Medicaid, MRC programs utilize an unreliable patchwork of funding mechanisms across the public and private sector, leading to challenges of incorporating and streamlining MRC; and be it further

RESOLVED, That our AMA work with Centers for Medicare & Medicaid Services and relevant state level institutions to establish consistent funding options for medical respite care; and be it further

RESOLVED, That our AMA work with Centers for Medicare & Medicaid Services, participating hospital groups, and relevant state level institutions to develop mechanisms by which hospitals are incentivized to implement the use of medical respite care; and be it further

RESOLVED, That our AMA partner with relevant hospital groups and institutional bodies to facilitate the integration, maturation, and expansion of medical respite care as part of a comprehensive discharge plan for homeless patients; therefore be it

RESOLVED, That our AMA support legislation that would increase the utilization of medical respite care by hospitals; and

RESOLVED, That our AMA work with appropriate stakeholders, such as the National Healthcare for the Homeless Council, to improve the methods of evaluating medical respite centers compliance to quality standards.

Fiscal Note: Significant, 10

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children’s Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children’s Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children’s Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

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

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

Resolution: 43
(I-17)

Introduced by: Regions 5 and 7; Gwendolyn Lee, Oscar G. Echeverria, and Abhinaya
Narayanan, David Geffen School of Medicine at UCLA; Giovanni
Rodriguez, Indiana University School of Medicine; Garrett Hall, Touro
University California College of Osteopathic Medicine

Subject: Presence and Enforcement Actions of U.S. Immigration and Customs
Enforcement (ICE) at Healthcare Facilities

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, U.S. Immigration and Customs Enforcement (ICE) policy states that
enforcement actions, including interviews, searches, apprehensions, or arrests, should
not occur at sensitive locations, including healthcare facilities and medical treatment
centers, such as hospitals, health clinics, doctors' offices, and emergent or urgent care
facilities; and

Whereas, Recent efforts by ICE's outreach program have involved approaching a
hospital on the grounds of establishing a partnership to "develop potential sources of
information" and enlist healthcare facilities in sharing patient information, or even
conducting enforcement actions at hospitals, effectively undermining the explicit
designation of this and other sites as sensitive locations; and

Whereas, The current Presidential administration has requested $1 billion to accelerate
and expand the detention and deportation of undocumented immigrants, and the number
of ICE arrests made in the first 100 days of the current administration reflects an
increase of 37.6% over the same 100-day period from January to April in 2016; and

Whereas, The establishment of partnerships, or even the fear of partnerships, between
ICE and community health care facilities, and the corresponding increases in detention
and deportation efforts have been shown to increase deportation fears among
immigrants, erode immigrant trust in community health institutions, and lead to poorer
health outcomes for both documented and undocumented immigrants; and

Whereas, Hospitals across the nation, from Santa Rosa, CA to Brooklyn, NY have
shared recent reports that the presence of and fear of immigration officials at healthcare
facilities contributed to decreased healthcare utilization and use of preventive care, with
patients canceling their appointments at up to twice the rate of normal cancellation rates
at some hospitals, as well as appointment cancellations even when rumors of ICE
agents on the hospital campus were false; and
Whereas, The decreased utilization of healthcare affects non-immigrants as well, as undocumented parents are often deterred from bringing their children, who are U.S. citizens, to doctor’s appointments, for example, and this in turn translates to fewer children receiving their childhood vaccinations for communicable diseases, such as measles and meningitis, that do not differentiate who to infect based on immigration status; 

Whereas, Section 164.512 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits disclosure of protected health information only in instances that involve averting a serious threat to health or safety, when there was a violation of the law involving a crime that occurred on the premises or required emergency health care, or if the patient was the victim of a crime; 

Whereas, Ongoing subversion of the sensitive location policy by ICE has prompted pending congressional legislation to codify this policy into law and thereby ensure that undocumented immigrants are able to access health care, among other social services, without fear of deportation; and 

Whereas, Existing AMA policy calls for our AMA “to support protections that prohibit... law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented” (H-315.966); and 

Whereas, Existing AMA policy calls for our AMA to “[advocate] for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees” (H-350.957); therefore be it 

RESOLVED, That our AMA make an immediate statement to support the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur, and oppose the presence of ICE at such healthcare facilities; and be it further 

RESOLVED, That our AMA advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations by law; and be it further 

RESOLVED, That our AMA educate medical providers on the rights of undocumented patients while receiving medical care, regarding protection from immigration enforcement action and the negative health implications that this social determinant can have on undocumented patients, in order to properly provide care to this population. 

RESOLVED, That our AMA encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations, and the responsibility of physicians not to disclose documentation status of any patient, via a variety of forms including but not limited to visible posters, flyers, websites, or other such public announcements.
References:


2. U.S. Immigration and Customs Enforcement, Morton J. *Enforcement Actions at or Focused on Sensitive Locations*. Policy number: I0029.2. FEA Number: 306-112-002b


12. Queally J. Latinos are reporting fewer sexual assaults amid a climate of fear in immigrant communities, LAPD says. Los Angeles Times.


RELEVANT AMA AND AMA-MSS POLICY:

**Patient and Physician Rights Regarding Immigration Status H-315.966**
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

**Medical Care Must Stay Confidential H-270.961**
Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.

**Addressing Immigrant Health Disparities H-350.957**
(1) Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (2) Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available
and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

**Racial and Ethnic Disparities in Health Care H-350.974**

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

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

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

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

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

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

**Police, Payer, and Government Access to Patient Health Information H-315.975**

1. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

2. Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.
Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions
against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other
uses are to be made of the information, patients must first give their uncoerced
permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy
groups and the public health community, should continue its advocacy for privacy and
confidentiality regulations, including: (a) The establishment of rules allocating liability for
disclosure of identifiable patient medical information between physicians and the health
plans of which they are a part, and securing appropriate physicians' control over the
disposition of information from their patients' medical records. (b) The establishment of
rules to prevent disclosure of identifiable patient medical information for commercial and
marketing purposes; and (c) The establishment of penalties for negligent or deliberate
breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public,
physicians and policymakers at all levels of government about concerns and
complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians
and departments is appropriate for the purpose of addressing public health emergencies
or to comply with laws regarding public health reporting for the purpose of disease
surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be
notified whenever possible and asked for authorization to transfer the medical record to
a new physician or care provider. Only de-identified and/or aggregate data should be
used for "business decisions," including sales, mergers, and similar business
transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient
confidentiality is the relevant state medical practice act. Knowing and intentional
breaches of patient confidentiality, particularly under false pretenses, for malicious harm,
or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the
federal level that will afford patients protection against discrimination on the basis of
 genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior
written and signed consent from patients to use their personal data for marketing
purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains
to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using
prescription refill reminders or disease management programs as an opportunity for
marketing purposes.
Whereas, Title V Abstinence Education Program Funding and/or Abstinence Only Until Marriage Funding, hereby referred to as AOUM, is currently accepted by 36 states, Guam, the Federated States of Micronesia, and Puerto Rico; and

Whereas, Abstinence-only sex education is now 23% of the sex education received by students in public middle and high schools; and

Whereas, Nearly all of the young girls and women who pledge themselves to abstinence only education plans break their promise and are 50% more likely to experience a nonmarital pregnancy; and

Whereas, Youth in countries that provide contraceptive education and counseling experience significantly lower birth and pregnancy rates than peers the same age in the United States; and

Whereas, The United States ranks first among developed nations for rates of teenage pregnancy and transmission of STIs; and

Whereas, AOUM programs have been shown to have no impact on the age of sexual initiation, number of partners, or contraceptive use, and conversely, comprehensive risk reduction programs decreased sexual activity, number of sex partners, frequency of unprotected sexual activity, STIs, and pregnancy, while increasing use of protection; and

Whereas, As of 2014, a nationally representative survey found 74% of Americans in favor of taxpayer-funded efforts to prevent teen pregnancy to be invested in programs proven to delay sex, improve contraceptive use, and/or prevent teen pregnancy; and

Whereas, By 2009 nearly half of all states refused Title V AOUM funding due to increasing concerns regarding restrictive program requirements and program efficacy; and

Whereas, Congress has spent over $2 billion on domestic abstinence only programs and has dedicated $75 million more for the 2017 fiscal year despite increasing concerns regarding program efficacy; and

Whereas, AOUM programs are found to cause an increase in white and black teen birth rates, while Medicaid family planning waivers are found to reduce teen birth rates across all ages and races; and
Whereas, Title X sets national standards for comprehensive, voluntary, confidential and affordable family planning services; and

Whereas, Title X-funded clinics provide the ideal setting for the contraceptive needs of the teens and young adults, had more outreach activities for teenagers, and had more staff specifically trained for teenage contraceptive needs; and

Whereas, Title X-funded programs offer both sexual educational services and counseling for youth; and

Whereas, In 2014 alone, Title X-funded clinics helped avoid 904,000 unintended pregnancies, 439,000 unplanned births, and 326,000 abortions, decreasing unintended pregnancy, unplanned birth, and abortion by 30%, and teen pregnancy by 30%; and

Whereas, over two decades, Title X-funded clinics helped prevent 5.5 million adolescent pregnancies and 2 million abortions among young women; and

Whereas, Title X funding currently is not sufficient to meet the needs of the program’s client population and cutting the current funding would cause an estimated additional 860,000 unintended pregnancies and 810,000 abortions; therefore be it

RESOLVED, That our AMA work with individual state medical societies to advocate state-by-state rejection of Title V Abstinence Education Funding; and be it further

RESOLVED, That our AMA advocate for the reallocation of Title V Abstinence Education Program Funding or any other Abstinence Only Until Marriage Funding program funding to Title X Family Planning Program Funding.

Fiscal Note: Significant, 11

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

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

Our AMA:

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for
providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

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

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

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

An Updated Review of Sex Education Programs in the United States H-170.962
Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy.
Whereas, According to data from the NRMP, there were nearly 5,000 more active applicants for the match than there were potential positions to be filled in 2016\(^1\); and

Whereas, Since 2007, matriculation at US medical schools has increased 18.4\(^2\)% while GME spots have only increased 12.9\(^3,4\); and

Whereas, While D-305.967 does state that, “Our AMA will study the effect of medical school expansion that occurs without corresponding graduate medical education expansion”, it does not ask the AMA to study any proposals which aim to combat the medical school expansion without corresponding graduate medical education expansion.

Whereas, Requiring new or existing medical schools, who intend to increase the state’s number of matriculated students into medical school, to submit a plan detailing how they envision GME spots increasing proportionately to the proposed increase in medical students would help ensure that the gap between the number of applicants for GME positions and the number of positions does not grow further; and

Whereas Texas recently unanimously passed Senate Bill 1066\(^5\), which accomplishes the previous whereas clause; therefore be it

RESOLVED, That Our AMA-MSS support policies which aim to stabilize and/or reduce the gap created by increasing medical school matriculation at higher rates than graduate medical education.

RESOLVED, That Our AMA-MSS amend 200.016 by addition to read,

“AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education or result in an increasing number of medical school graduates who are unable to match into graduate medical education positions.”

Fiscal Note: Minimal, 4

Date Received:

References:
1. Results of 2016 NRMP Main Residency Match Largest on Record as Match Continues to Grow. NRMP.org. Published March 18, 2016.


4. Results and Data; 2016 Main Residency Match. nrmp.org. Published April 2016.


RELEVANT AMA AND AMA-MSS POLICY:

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty,
should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the “General Requirements” section of the “Essentials of Accredited Residencies.” (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.
The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

Specialty boards should consider having members of the public participate in appropriate board activities.

Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant’s knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

The medical profession should continue to encourage participation in continuing medical education related to the physician’s professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.

Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care
delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.

(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.
4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.

5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state’s healthcare workforce and health outcomes.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and patient care.

8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. OurAMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future
physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will study the effect of medical school expansion that occurs without corresponding graduate medical education expansion.

32. Our AMA will advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-
setting deadline for new residency programs in underserved areas and/or economically depressed areas.

**Funding to Support Training of the Health Care Workforce H-310.916**

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

**Securing Funding for Graduate Medical Education H-310.917**

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

**Principles for Graduate Medical Education H-310.929**

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

1. PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

2. RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
3. EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

4. SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

5. FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

6. INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

7. COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

8. LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be
modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

9. PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

10. INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

11. THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

12. SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

13. EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

14. GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
15. VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

D-310.968 Physician and Medical Student Burnout
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

Accreditation of Graduate Medical Education Programs H-310.997
1. The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training.
2. The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

(2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

(3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
(4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

(5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

(6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

(7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

(8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

(9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

(10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

(11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

(12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

Supporting the Expansion of U.S. Residency Programs - 200.015MSS
AMA-MSS supports increases in the number of residency positions according to AMA workforce studies, where such increases would not undermine existing physician residency positions in any of the states.

Increasing Medical School Class Sizes - 200.016MSS
AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education.
Resolution: 46
(I-17)

Introduced by: AMA-MSS Region 5
Kevin Kuo, Matthew Hollowell, Ashleigh Omorogbe, Giovanni Rodriguez,
Arvind Haran, Ashleigh Bush, Indiana University School of Medicine;

Subject: Expansion of Office-based Opioid Treatment

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Opioid abuse and dependence continues to increase in prevalence within the United States, but availability of addictions treatment resources remains limited. The 2012 national rate of opioid abuse or dependence was 891 per 100,000 people, but the national rates of maximum potential treatment using buprenorphine and methadone were 420.3 and 119.9 per 100,000 people, respectively;¹

Whereas, Methadone is an effective treatment for opioid use disorder (OUD) but is not allowed in office-based opioid addiction treatment. Methadone for opioid addiction treatment is allowed only in federally-licensed narcotic treatment programs (NTP) overseen by the U.S. Department of Justice Drug Enforcement Administration (DEA);²,³

Whereas, Federal law and regulations do not restrict prescription of methadone for treatment of pain when deemed medically necessary by a registered practitioner;⁴

Whereas, The safety of methadone for use in treatment of OUD is comparable to that of buprenorphine, but buprenorphine is allowed in office-based opioid addiction treatment with a physician’s waiver involving 8 hours of training;⁵-⁸

Whereas, Patients with OUD are not always sufficiently managed on buprenorphine in an office-based setting and may require transfer to methadone therapy in a federal narcotic treatment program, disrupting continuum of care;⁹

Whereas, Methadone may be used to address the complex needs of patients with both chronic pain and opioid addiction, but office-based providers may only prescribe methadone for pain;¹⁰

Whereas, Diversion of methadone is associated with a lack of access to medication for OUD rather than recreational use;¹¹-¹³

Whereas, Federally-licensed narcotic treatment programs are concentrated in urban centers, and up to 26% of patients must travel more than 15 miles and over 20% of patients must cross state borders to access treatment programs;¹⁴-¹⁶

Whereas, Patients using methadone for OUD must travel to their clinic daily to receive a dose under supervision unless granted special take-home privileges based on criteria including: behavior, criminal activity, compliance, and social stability. In the first 90 days of treatment,
take-home supply is limited to a single dose per week; in the second 90 days, it is limited to two doses per week; and

Whereas, AMA policy H-95.957 supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to qualified office-based physicians but does not address regulations surrounding the prescription of methadone, a drug approved by the FDA in 1947; and

Whereas, The American Society of Addiction Medicine (ASAM) and the National Institutes of Health (NIH) have supported the authorization of Schedule II medications including methadone for use in office-based opioid treatment and the authorization of qualified physicians to provide methadone for addictions independent of a federal narcotic treatment program; and therefore be it

RESOLVED, That our AMA amend policy H-95.957 by addition and deletion to read as follows:

Our AMA: (1) reaffirms its position that, “the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal” (called “medical” maintenance) should be evaluated further;

(2) supports the position that “medical” methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;

(3) encourages additional research that includes consideration of the cost of “medical” methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;

(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications including methadone available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and

(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.

Fiscal Note: Minimal, 5

Date Received: 9/20/17
References:

RELEVANT AMA AND AMA-MSS POLICY:
Methadone Maintenance in Private Practice H-95.957
Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further;
(2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;
(3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;
(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and
(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management.

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

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.
Whereas, Recent research has contributed to growing evidence that refugees are at an increased risk of developing chronic mental health disorders, such as Post Traumatic Stress Disorder (PTSD), depression, and anxiety; and

Whereas, Refugees are likely to show significant psychiatric symptoms during the initial resettlement process; and

Whereas, Early detection of psychiatric disorders in refugees that include PTSD, depression, and anxiety can result in refugees who feel less marginalized and are better able to contribute to their families and society; and

Whereas, AMA policy H-350.957 broadly supports addressing immigrant health disparities; and

Whereas, The CDC publishes guidelines known as The Domestic Medical Examination for Newly Arriving Refugees, which are intended to guide a “comprehensive medical evaluation,” and

Whereas, The CDC underscores the importance of screening for chronic mental health disorders by explaining that “Depression and PTSD are prevalent in refugees who are not in clinical care for mental health,” ; and

 Whereas, The Office of Refugee Resettlement (ORR) in 2013 published a national Domestic Medical Screening Guidelines (DMSG) checklist and accompanying state letter summary that is used by practitioners as a protocol for evaluating newly arrived refugees for chronic and acute medical problems; and

Whereas, the ORR’s DMSG state letter, while endorsing the CDC’s corresponding guidelines, contradicts itself by stating that “The purpose of the mental health screening is to assess for acute psychiatric emergencies such as suicidal and homicidal ideation,” ; and

Whereas, The DMSG checklist includes other chronic health conditions such as Hepatitis B and C testing, but makes no mention of chronic mental health conditions such as PTSD, depression, and anxiety; and
Whereas, Effective evidence-based mental health screening tools, such as the Refugee Health Screener - 15 (RHS-15) and the CRIES-8 questionnaire, have been developed with high sensitivities for detecting mental health conditions in refugees \(^5,12\); and

Whereas, The American Academy of Pediatrics specify a separate mental health section on their own screening checklist for arriving refugees that includes screening for PTSD, depression, and anxiety, along with the use of refugee specific mental health screening tools such as the RHS-15 \(^13\); and

Whereas, Certain states such as Washington and Connecticut have modified the ORR’s checklist for use in their respective states with the addition of sections for comprehensive mental health exams that include refugee specific mental health screening tools such as the RHS-15 \(^14,15\); and

Whereas, The ORR does not guarantee reimbursement to state medical institutions for conducting exams not included on the national ORR DMSG checklist \(^8\); and

Whereas, Physicians are more likely to perform procedures and examinations if they will be reimbursed for them \(^9\); and

Whereas, Inadequate reimbursement rates have been identified as a barrier to health care in refugee populations \(^10,11\); and

Whereas, The omission of chronic mental health conditions from the national ORR DMSG checklist and state letter underscores the lack of parity between physical health services and mental health services in refugees, be it

RESOLVED, That our AMA advocate for the updating of the Office of Refugee Resettlement’s “Revised Medical Screening Guidelines for Newly Arriving Refugees” state letter to emphasize the importance of chronic mental health disorders, such as Post Traumatic Stress Disorder, depression, and anxiety, and be it further

RESOLVED, That our AMA advocate for the updating of the Office of Refugee Resettlement’s “Domestic Medical Screening Guidelines” checklist to create a separate section for mental health screening that includes distinct screening for chronic mental health disorders including but not limited to Post Traumatic Stress Disorder, depression, and anxiety.
References


Relevant AMA Policy:

**H-350.957 Addressing Immigrant Health Disparities**
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

Res. 804, I-09Appended: Res. 409, A-15

**H-350.956 Increasing Access to Healthcare Insurance for Refugee Populations**

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

Res. 006, A-17

**D-345.994 Increasing Detection of Mental Illness and Encouraging Education**

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res. 412, A-06Appended: Res. 907, I-12Reaffirmed in lieu of: Res. 001, I-16

Relevant MSS policy:

**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)

**250.027MSS Emphasizing Training in the Treatment of Refugees**

AMA-MSS supports medical student collaboration with appropriate entities for training in the provision of refugee medical care. (MSS Res 08, I-16)

**250.028MSS Increasing Access to Healthcare Insurance for Refugees**
AMA-MSS will ask that our AMA support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize
gaps in health-care for refugees. (MSS Res 05, I-16) (AMA Res 006, A-17 Adopted)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 48
(I-17)

Introduced by: Brandon Tabman, The Ohio State University College of Medicine; Julie Bittar, Indiana University School of Medicine; Andy Zureick, University of Michigan Medical School

Subject: Standardization of Medical Licensing Time Limits Across States

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, 31 states have a set time limit of 7 years to complete the USMLE licensing sequence, 29 states allow 10 years specifically for MD/PhD student, 37 states allow 10 years for DO/PhD students to complete the COMLEX sequence, and at least 20 states have different time limits for USMLE and COMLEX sequences;¹ and

Whereas, 7 states have no time limit to complete the USMLE sequence, and at least 22 states have no time limit to complete the COMLEX sequence;¹

Whereas, Of the state medical and osteopathic boards which have a time limit, 10 years with potential waivers is the greatest of the time limits;¹

Whereas, A recent study by Holmes et al. (2017) measures the average time to complete social science and humanities MD/PhDs to be 9 years;² and

Whereas, All state licensing jurisdiction require 1 year of graduate medical education before licensure for US medical graduates, 12 states require 2 years and 25 states require 3 years of accredited graduate medical education for foreign medical graduates;³,⁴ and

Whereas, Current AMA Abolish Discrimination in Licensure of IMGs H-255.966 calls for the elimination of disparities in graduate training requirements for licensure; and

Whereas, Opportunities such as moonlighting can depend on having a full medical license;⁵ and

Whereas, The lack of a nation-wide policy leads to situations where students with identical training timelines have differing ability to obtain a license, simply depending on the state’s policy where they receive training; therefore be it

RESOLVED, That our AMA amend H-275.978 Medical Licensure by addition as follows:

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

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

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

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

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

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

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

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

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

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

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

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

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.

and be it further

RESOLVED, That our AMA-MSS formally establishes support for the following HOD policies:

Medical Licensure H-275.978, Alternatives to the Federation of State Medical Boards
Recommendations on Licensure H-275.934, Abolish Discrimination in Licensure of IMGs H-255.966

Date Received: Minimal, 5

References

RELEVANT AMA AND AMA-MSS POLICY:

Medical Licensure H-275.978
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the
health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Level 1 of COMLEX USA. There should be provision made for students who have not completed Step 2 of the USMLE or Level 2 of the COMLEX USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Level 1 of COMLEX USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants.

Abolish Discrimination in Licensure of IMGs H-255.966

Medical Licensure of International Medical Graduates
1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):
   A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
   B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
   C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
   D. U.S. states and territories retain the right and responsibility to determine the
qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

255.003MSS Licensure of International Medical Graduates
AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the development of separate licensing criteria, including exams, for any group.

275.001MSS Competence for Licensure
AMA-MSS will ask the AMA to: (1) urge state licensing authorities to continue to recognize the NBME certificate; (2) recommend that medical school faculties continue to exercise responsibilities for evaluating students and housestaff; (3) oppose a licensing examination as a requirement for graduates of educational programs accredited by the LCME to enter the first year of graduate training; (4) oppose requirements for licensure requiring a long period of graduate education with the attendant risk of licensure by specialty; and (5) support a single FLEX examination sequence, during or shortly after the first year of graduate medical education.
Whereas, Medical student mental health is a topic that continues to be at the forefront of the discussion of medical education;¹⁸ and

Whereas, Our American Medical Association delegates have identified a need to pursue innovative mechanisms to improve medical student wellness and mitigate burnout;⁹ and

Whereas, A recent meta-analysis of studies on medical student depression and suicidality estimated the overall pooled prevalence of depression or depressive symptoms was 27.2% and suicidal ideation was 11.1%, with only 15.7% of students who screened positive for depressive symptoms seeking psychiatric care;⁴ and

Whereas, Peer-led mental health programs implemented in secondary schools and university settings have shown improvements in help-seeking behaviors, suicide perceptions, social integration, and anxiety levels of students;¹⁰⁻¹² and

Whereas, Evidence exists on the effectiveness of peer support and mindfulness in improving the psychological well-being of medical students through peer-led programs;¹³ and

Whereas, Peer-led mindfulness training and suicide prevention programs can be easily adapted and integrated into the medical school curriculum to further improve on competencies in managing mental health resilience, communication and psychosocial approach to care;¹⁴ and

Whereas, Training programs, such as SafeTalk, exist for laypeople to learn how to recognize the signs of a person at risk of suicide, identify invitations for help, approach a person at risk of suicide, ask a person about suicide, and connect a person at risk of suicide with professional help;¹⁵ and

Whereas, The Safetalk program was implemented at a veterinary school with successful results: "The vast majority of the students reported that after completing the workshop they were more likely or much more likely to recognise the signs of a person at risk of suicide, approach a person at risk of suicide, ask a person about suicide, and connect a person at risk of suicide with help.";¹⁶ therefore be it

RESOLVED, That our AMA-MSS encourage medical schools to implement suicide prevention training programs so that medical students can take an active role in promoting medical student mental health and suicide prevention.

Fiscal Note: Minimal, 5
References:


RELEVANT AMA AND AMA-MSS POLICY:

295.001MSS – Support Groups

310.054MSS – Preventing Resident Physician Suicide
AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create a supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

345.004MSS – Stigmatization of Mental Health disorders within the Medical Profession
AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization. (MSS Res 37, A-11) (Modified: MSS GC Report A, I-16)

345.011MSS – Improving Mental health at Colleges and Universities for Undergraduates
AMA-MSS will ask (1) that our AMA support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; (2) that our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and (3) that our AMA support collaborations

345.015MSS – Addressing Social Media Usage and its Negative Impacts on Mental Health
AMA-MSS will ask that our AMA (1) collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians’ knowledge of the health impacts of social media usage, and (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and (2) advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage. (MSS Res 41, A-17)

H-345.970 – Improving Mental Health Services for Undergraduate and Graduate Students
Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and
universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

H-295.999 – Medical Student Support Groups
(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.
(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 50
(I-17)

Introduced by: Cindy Tsui, Eric Hirsch, SUNY Downstate College of Medicine; Geetika Srivastava, Louisa Liu, Julie Lin, Northeast Ohio Medical University; Jawad Arshad, Case Western Reserve University School of Medicine; Kara Richardson, University of Toledo School of Medicine

Subject: Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Women

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Feminine hygiene products are defined as “tampons, pads, liners, cups, sponges, douches, wipes, sprays, and similar products used by women with respect to menstruation or other genital-tract secretions”;¹ and

Whereas, Our AMA defines medical necessity as a product a physician “would provide for the purpose of preventing” an illness, disease, or its symptoms (H-320.953); and

Whereas, Our AMA supports the evaluation of medical necessity “based on established and evidence-based clinical criteria” (H-320.942); and

Whereas, Globally, studies have shown a correlation between increased access to feminine hygiene products and improved reproductive health. Poor menstrual hygiene is correlated with significant adverse health effects, including increased urogenital infections and cervical cancer;² and

Whereas, Poor menstrual health is associated with significant healthcare costs and a reduced quality of life, especially in women with heavy menses;³ and

Whereas, Women in the United States spend $2 billion annually on menstrual products, and the average woman needs more than 16,800 pads and tampons over her lifetime;⁴ and

Whereas, The biggest barriers to adequate feminine hygiene are affordability and accessibility;⁵ and

Whereas, Women who are incarcerated, homeless, or of low socioeconomic status often resort to cheaper and less sanitary alternatives such as newspapers and used rags, and are therefore particularly vulnerable to health complications caused by poor menstrual hygiene;⁶, ⁷, ¹¹-¹³ and

Whereas, More than 100,000 women are held in correctional facilities each year, over 80% of whom are between 18 to 50 years of age. Women in or released from the prison system widely report inconsistent accessibility of feminine hygiene products and their use as “bargaining chips” by correctional officers;¹⁴, ¹⁵ and

Whereas, White, Black, and Hispanic women earn 82 cents, 65 cents, and 58 cents, respectively, for every dollar earned by their white male counterparts. This disparity creates an
economic barrier to accessing feminine products that particularly affects minority and low-income women;\textsuperscript{16-18} and

Whereas, Women who qualify for the Supplemental Nutrition Assistance Program (SNAP) do not receive financial assistance for feminine hygiene products;\textsuperscript{19} and

Whereas, Women of low socioeconomic status often resort to trading food stamps in order to buy menstrual products;\textsuperscript{5,20} and

Whereas, The Internal Revenue Service (IRS) does not classify feminine hygiene products, such as pads and tampons, as medical necessities, wrongfully implying that menstrual products are not required for prevention, treatment, or diagnosis of a medical condition;\textsuperscript{21} and

Whereas, Menstrual products are currently ineligible for Flexible Spending Account (FSA), Limited Care FSA, Dependent Care FSA, Health Savings Account (HSA), or Health Reimbursement Arrangement (HRA) reimbursement;\textsuperscript{21} and

Whereas, The Food and Drug Administration (FDA) classifies menstrual products as medical devices, and they are regulated as such;\textsuperscript{22} and

Whereas, In a survey conducted by Feeding America, menstrual products were identified as "basic essentials" and "products that cannot be foregone or easily substituted" by all income groups;\textsuperscript{23} and

Whereas, The U.S. Department of Justice Federal Bureau of Prisons requires that a range of feminine hygiene products be provided free of charge to federal inmates;\textsuperscript{24} and

Whereas, AMA policy supports "improved access to comprehensive physical and behavioral health care services...throughout the incarceration process" to address the "distinctive health care needs of incarcerated women and adolescent females" (H-430.986); and

Whereas, Our AMA-MSS “supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters” (160.032MSS), but this resolution was not brought to the AMA House of Delegates; and

Whereas, Many national and state acts, such as the Fund Essential Menstrual (FEM) Products Act of 2015, are moving to remove taxes and qualify feminine hygiene products for FSA reimbursement;\textsuperscript{25} and

Whereas, AMA policy recognizes access to feminine hygiene products as a public health issue and supports the removal of sales tax on all feminine hygiene products (H-270.953); therefore be it

RESOLVED, That our AMA classifies, and encourages the Internal Revenue Service to classify, feminine hygiene products as medical necessities; and be it further

RESOLVED, That our AMA supports Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of feminine hygiene products; and be it further
RESOLVED, That our AMA supports consistent and ready access of feminine hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged women.

Fiscal Note: Moderate, 6

Date Received: 9/20/17

References:

1. H.R. 1708 to amend the Public Health Service Act to establish a program of research regarding the risks posed by the presence of dioxin, synthetic fibers, chemical fragrances, and other components of feminine hygiene products, H.R. 2015. HR 1708, 114th Cong.
   February 16, 2010.
22. Food and Drug Administration (FDA): Guidance for Industry and FDA Staff - Menstrual
   Tampons and Pads: Information for Premarket Notification Submissions.
   America.* September 19, 2013.
25. H.R. 3117 to amend the Internal Revenue Code of 1986 to provide for reimbursement
   from health flexible spending arrangements for feminine hygiene products, H.R. 2015.
   HR 3117, 114th Cong.

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

**Definitions of “Screening” and “Medical Necessity” H-320.953**

(1) Our AMA defines screening as: Health care services or products provided to an individual
   without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying
   or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word
   screening in the term "medical screening examination"; "The process required to reach, with
   reasonable clinical confidence, the point at which it can be determined whether a medical
   emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent
   physician would provide to a patient for the purpose of preventing, diagnosing or treating an
   illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally
   accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency,
   extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and
   purchasers or for the convenience of the patient, treating physician, or other health care
   provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy
   documents, including its "Model Managed Care Services Agreement." Usage of the term
   "medical necessity" must be consistent between the medical profession and the insurance
   industry. Carrier denials for non-covered services should state so explicitly and not confound
   this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services
   agreements to ensure that they do not contain definitions of medical necessity that emphasize
   cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and
   incorporate standards that prohibit the use of definitions of medical necessity that emphasize
   cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on
   information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to
   government agencies, managed care organizations, third party payers, and private sector health
   care accreditation organizations.
Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

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

160.032MSS Feminine Hygiene Products
Feminine Hygiene Products: Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelter. (MSS Res 17, I-16)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 51
(I-17)

Introduced by: Eric Sung, Oscar Reyes Gaido, Johns Hopkins School of Medicine

Subject: Appropriate Use of Clinical Decision Support Alerts

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, The majority of US hospitals have adopted electronic health record systems that meet federal meaningful-use criteria;¹ and

Whereas, Electronic health record systems utilize clinical decision support (CDS) to aid providers in clinical decision-making;² and

Whereas, CDS alerts are a form of clinical decision support that are displayed in electronic health records in both an interruptive and non-interruptive fashion;³ and

Whereas, CDS alerts have been shown to improve patient outcomes when used effectively;⁴ ⁵ ⁶ and

Whereas, Ineffective CDS alerts are overridden by clinicians with as high as 49-96% override rates because they are irrelevant and distracting to the clinician’s decision-making;⁷ ⁸ and

Whereas, Receiving too many ineffective CDS alerts can cause alert fatigue, where providers inadvertently disregard important alerts that may place patients at risk for adverse outcomes;⁹ and

Whereas, Alert fatigue can lead to patient safety issues, such as distracting the provider or obscuring a potential adverse drug interaction, if inappropriately designed alerts interrupt clinician workflow;¹⁰ ¹¹ and

Whereas, Measuring the efficacy of CDS alerts, through variables such as alert acceptance rate and time elapsed from generation to dismissal of an alert, can support the evidence-based development of effective alerts to prevent alert fatigue;¹² ¹³ and

Whereas, CDS alerts that minimize negative impact on clinician workflow, optimize user-friendly interactions, and reduce repeated notifications for a patient can lead to improved clinician acceptance of these alerts and improved patient outcomes;¹⁴ ¹⁵ ¹⁶ therefore be it

RESOLVED, That our AMA encourage the evidence-based design and use of clinical decision support (CDS) alerts; and be it further

RESOLVED, That our AMA encourage that clinical decision support (CDS) alerts be designed to minimize negative impact on clinician workflow, to facilitate user-friendly interactions, and to avoid redundant notifications for a given patient.
Fiscal Note: Moderate, 9

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:
National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

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

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976

1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey
physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.

2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.

3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

Medication Adherence H-373.993

Our AMA supports third parties in researching the effectiveness of personalized medication cards and other tools, including electronic reminders, intended to promote safe medication use, improve medication adherence, and improve health outcomes. Reminders should also be available in a variety of languages. Special attention should be devoted to reaching low literacy target audiences.

Patient Safety Incidents Related to Use of Electronic Health Records H-478.985

That our American Medical Association support the Office of the National Coordinator for Health IT (ONC) efforts to implement a Health IT Safety Center to minimize EHR-related patient safety risks through collection, aggregation and analysis of data reported from EHR-related adverse patient safety events and near misses.

Implementing Medication Reminder Systems 480.015MSS

AMA-MSS ask the AMA to support research into the efficacy of electronic reminder systems. (AMA Sub Res 12, A-15) (Amended Policy H-373.933 Adopted in Lieu of AMA Res 906)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 52
(I-17)

Introduced by: Pranjal Gupta, Rafa Rahman, Johns Hopkins University School of Medicine

Subject: Call to Study on the Reduction or Elimination of Medical Student Membership Dues

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Dues for medical students to join the AMA are currently $20 for 1-year membership, $38 for 2-year membership, $54 for 3-year membership, and $68 for 4-year membership; and

Whereas, The CLRPD A-17 Report on “Demographic Characteristics of the House of Delegates and AMA Leadership” found that 55,863 medical students are members of the AMA, comprising 23.2% of the total 240,498 AMA members; and

Whereas, According to the Committee on Long Range Planning and Development (CLRPD) A-13, A-15 and A-17 Reports on “Demographic Characteristics of the House of Delegates and AMA Leadership,” AMA membership has increased by 7.1% in the past four years, but AMA membership currently only represents 19.4% of the total physicians and students in the United States, compared to approximately 75% in the 1950s; and

Whereas, Given the current divisiveness of national debates surrounding healthcare, it is imperative for the AMA to present a strong and unified voice, which necessitates high membership rates; and

Whereas, the AMA 1998 Task Force on Membership emphasized importance of recruitment and retained membership in the AMA Medical Student Section, stating that “these members and potential members truly represent the future of our Association,” and that “there is an urgent need for the development of a life cycle approach to membership for these individuals”; and

Whereas, According to the CLRPD A-17 Report and AMA 2016 Annual Report, at the $20 yearly dues rate for medical students, the AMA’s 55,863 medical students would provide approximately $1.1 million in revenue, which is less than 3% of the AMA’s total 2016 dues revenue of $39.3 million, and less than 0.4% of the AMA’s total 2016 revenue of $323.7 million; and

Whereas, Medical school debt presents a significant financial burden to medical students, given that according to the AAMC, 76% of graduates of the Class of 2016 carried medical educational...
debt, and 82% of graduates owed $100,000 or more in debt including undergraduate education; and

Whereas, The AMA recognizes that excessive dues may present a burden for medical students, with existing AMA policy G-635.120; and

Whereas, Similarly, several state medical societies, such as California, Texas, Florida, Pennsylvania, Maryland, and Illinois, recognize the burden membership dues place on medical students by offering free membership for medical students; and

Whereas, The dues for medical student membership in the AMA are higher than that of student membership to other comparable professional societies, such as: the American Osteopathic Association, the American College of Physicians, the American College of Surgeons, the American Academy of Family Physicians, the American Bar Association, the National Society of Professional Engineering, which all offer students free yearly membership, and the American Nursing Association, which offers students a yearly membership for $10, a 50% reduction from the AMA yearly student membership; therefore be it

RESOLVED, that the AMA-MSS amend MSS Policy 655.002 by deletion and insertion as follows:

655.002 MSS Membership Recruitment Methods: AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial or full subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA AMA-MSS Digest of Policy Actions/ House of Delegates, with the goal of having a proportional number of delegate seats based on student membership. (MSS Rep I, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

and be it further

RESOLVED, That our AMA study alternative dues models for student membership in order to reduce or eliminate membership dues for medical students.
Fiscal Note: Minimal, 6

Date Received:

References:

RELEVANT AMA AND AMA-MSS POLICY:
Dues Strategies G-635.120
AMA’s dues strategies include the following: (1) It is the constitutional duty of our AMA House of Delegates to set the membership dues structure. (a) Any reduction of the level of dues within each category of membership can only be done with the approval of the House of Delegates; and (b) Our AMA Board of Trustees will actively seek to obtain the cooperation of the state and component medical societies before and during any negotiations on reductions in the level of dues for groups. (2) Relying upon survey and other relevant data, our AMA Board of Trustees shall determine the dues and benefits of the International membership category. (3) Any Federation component choosing to continue to bill and collect AMA dues shall have signed a binding primary partnership agreement with our AMA. A binding primary partnership agreement for AMA membership billing and dues collection shall include the following elements: (i) utilization of our AMA standard membership application; (ii) acceptance of credit card payments for AMA dues; and (iii) agreed-upon performance standards and incentives. (4) Our AMA encourages state and local medical societies, and our AMA, to explore new programs, activities and services which can provide meaningful benefits to members, produce additional non-dues income for medical societies, make it possible to hold the line on dues, and provide potentials for increasing physician membership. (5) Our AMA commends those medical societies which are endeavoring to hold the line on dues as a responsive action to the needs of their members. (6) Our AMA and its constituent state and county medical societies should implement a policy whereby, upon written request from a member or appropriate staff member of a medical society, there would be a transfer of prepaid dues to the receiving county or state medical society upon receipt and acceptance of an application for membership transfer, so long as the dues were paid and transfer application received before the calendar/dues year began, or within 31 days thereafter. (7) Our AMA urges all county and state societies to review their dues structure for medical students so that the total dues for county, state, and AMA membership can be held to a realistic figure. (8) Our AMA should develop and implement a dues program specifically designed to bridge the gap caused by the transition from residency into the first years of practice. It should implement multi-year dues options that span the transition periods from student to resident and/or resident to young physician and provide periodic benefits at specific points during the multi-year membership. (9) Our AMA membership dues delinquency date is March 1. Direct membership solicitation of dues-delinquent members is appropriate according to the individual Partnership for Growth agreements with state medical societies. (10) Our AMA will make a major organizational effort to persuade physicians’ employers to allocate funds for professional development and Federation dues. (11) The House of Delegates approves the Partnership for Growth? s Direct Program marketing entry date of February 1.

Current AMA Dues G-635.130
The Board of Trustees recommends no change to the dues levels for 2018:
Regular Members $420
Physicians in Their Second Year of Practice $315
Physicians in Military Service $280
Physicians in Their First Year of Practice $210
Semi-Retired Physicians $210
Fully Retired Physicians $84
Physicians in Residency Training $45
Medical Students $20

Duties and Privileges B-5.3
In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws. 5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA’s Executive Vice President. 5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter. 5.3.2 Planning. Serve as the principal planning agent for the AMA. 5.3.2.1 Planning focuses on the AMA’s goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA’s Councils, Sections, and other appropriate AMA components. 5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA’s vision, goals, and priorities. 5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions. 5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA’s vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House. 5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession. 5.3.5 Election of Secretary. Select a Secretary from one of its members annually. 5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President. 5.3.6.1 The Executive Vice President is the chief executive
officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees. 5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation. 5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program. 5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office. 5.3.7 Finances. Maintain the financial health of the AMA. The Board shall: 5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA’s vision, goals, and priorities. 5.3.7.2 Ensure that the AMA’s resource allocations are aligned with the AMA’s plan and budget. 5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates. 5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA’s revenues and expenses. 5.3.7.5 Have the accounts of the AMA audited at least annually. 5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting. 5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA. 5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy. 5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board. 5.3.9.1.2 An advisory committee will not have representation in the House of Delegates. 5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years. 5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce. 5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time. 5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws. 5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

Membership Recruitment Methods 655.002MSS
AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA AMA-MSS Digest of Policy Actions/ 131 House of Delegates, with the goal of having a proportional number of delegate seats based on student membership. (MSS Rep I, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
Whereas, Rural populations comprise about 20% of the US population;¹ and

Whereas, Poor vision health severely impacts school and work performance, quality of life, and life expectancy;²,³ and

Whereas, The visually impaired have a 13% lower graduation rate from high school, a 9% lower graduation rate from college, and earn $9000 less annually on average than their peers without visual impairment;⁴ and

Whereas, Comprehensive eye exams that include tests beyond screening with eye charts, conducted by an optometrist or ophthalmologist, can lead to fewer undiagnosed problems and improved prognosis;⁵,⁶ and

Whereas, Rural populations and low-income groups appear to be at higher risk for vision problems compared to wealthier and urban Americans;²,⁷,⁸ and

Whereas, The national median driving time to an ophthalmologist is 4.52 minutes, but 90% of the US Medicare beneficiary population lies within a 30-minute drive to the nearest ophthalmologist, demonstrating that those most in need of ophthalmic services live in medically underserved geographic areas;⁹ and

Whereas, 88% of patients who attended their referral ophthalmic appointment after being screened in rural areas in the US had abnormal examination findings such as refractive error, glaucoma, retinal diseases (choroidal nevus, early age-related macular degeneration, history of retinal tear, and a history of retinal scar), amblyopia, and cataracts;¹⁰ and

Whereas, Major barriers to providing on-site comprehensive eye care services include the lack of access to qualified vision care professionals and inadequate reimbursement from Medicaid, Medicare, and private insurers, presenting a major challenge for persons in low-income communities and geographically isolated and medically underserved areas, including rural areas;²,⁸ and

Whereas, In a report published as a collaboration between the National Academies of Sciences, Engineering, and Medicine, the Health and Medicine Division, the Board on Population Health...
and Public Health Practice, and the Committee on Public Health Approaches to Reduce Vision Impairment and Promote Eye Health, authors urge the Secretary of the US Department of Health and Human Services to issue a call to action which includes achieving eye and vision health equity by improving access to vision care in underserved populations;¹ and

Whereas, Seven out of 10 health centers do not staff on-site eye care professionals to provide comprehensive eye exams, and many health centers rely on referral arrangements with local optometrists and ophthalmologists for such services;² and

Whereas, None of the rural community health centers in the U.S. have an ophthalmologist on-site;² and

Whereas, Screening at community health centers is likely to yield a high referral attendance rate for this at-risk population and facilitate entrance into the eye care system in a rural setting;¹⁰ and

Whereas, Patients’ lack of understanding about the need for routine eye exams requires that strategies to improve access to vision care must include education about the importance of routine eye care exams;² and

Whereas, Pilot programs aimed at delivering eye care services in Asia have improved eye health knowledge and access to vision services in rural areas;¹² therefore be it RESOLVED, That our AMA support legislation at the national level to advocate for comprehensive vision care in community health centers; and be it further

RESOLVED, That our AMA support the development of financial incentives for placement of eye care professionals in underserved communities; and be it further

RESOLVED, That our AMA support educational programs focusing on the importance of routine eye care exams.

Fiscal Note: Minimal, 6

Date Received: 9/20/17

References:


**Relevant AMA and AMA-MSS Policy:**

**60.010MSS: Encouraging Vision Screenings for School Children**
AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate.  

**440.025MSS: Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes**
AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver’s license who fail a vision screening at their respective Department of Motor Vehicles to an appropriate healthcare provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable.  (MSS Res 16, A-05) (AMA...

Formal support of H-425.977
The MSS formally establishes support for the following HOD policy: H-425.977 Encouraging Vision Screenings for Schoolchildren Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on American Academy of Pediatrics, American Academy of Family Physicians and American Academy of Ophthalmology evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. (Res. 430, A-05)
MSS Res 49, A-15

440.006MSS: Ocular Sun Damage to the Retina and its Prevention
AMA-MSS will ask the AMA to: (1) support efforts to educate the general public about the potential long term effects of sun and bright light exposure, and the possible benefit derived from wearing protective eye wear blocking out radiation of wavelengths of less than 500nm in preventing AMA; and (2) incorporate this issue into existing health education efforts. (AMA Res 12, A-91 Referred) (BOT Rep T, I-91 Filed) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

H-425.977 Encouraging Vision Screenings for School Children
Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. Res. 430, A-05; Modified: CSAPH Rep. 1, A-15.

H-25.990 Eye Exams for the Elderly
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15.
Whereas, Gene therapy is defined as “an experimental technique that uses genes to treat or prevent disease.”;¹ and

Whereas, Gene therapies in both human clinical trials and murine models have been shown to be effective in promoting endogenous production of various proteins such as erythropoietin, insulin-like growth factor-1, and vascular endothelial growth factor;²,³,⁴,⁵,⁶ and

Whereas, While the therapeutic benefits of such technology is promising, many are also considering the potential for misuse of such technology, including “gene doping”; and

Whereas, In 2008, the World Anti-Doping Agency (WADA) defined gene doping as the “nontherapeutic use of cells, genes, genetic elements, or modulation of gene expression, having the capacity to enhance performance.”;⁷,⁸ and

Whereas, Although to date there have been no confirmed instances of gene doping, the potential societal and health related consequences of gene doping have prompted a prophylactic investigation into detection techniques and the denouncement of such activity by many of the major governing bodies in this arena, including the International Olympic Committee (IOC), WADA, and various International Sports Federations;⁹,¹⁰,¹¹ and

Whereas, While the major institutional bodies relevant to doping in sports have condemned the use of gene doping, public opinion may diverge, as recent evidence suggests that the general population may be in greater support of gene doping without consideration for ethical and medical repercussions;¹²,¹³ and

Whereas, Though the major sequelae of gene doping are still uncertain, potential long term effects have manifested as cancers, heart failure, and stroke;⁸,¹⁴,¹⁵ and

Whereas, While there is speculation that the technology to adequately detect gene doping in athletes already exists, no standardized protocol has yet to be developed for the detection or regulation of any type of gene doping in athletes;¹⁴,¹⁵,¹⁶,¹⁷,¹⁸,¹⁹ and

Whereas, While our AMA has recognized and supported the potential therapeutic effects of genomic editing (H-480.945) and denounced the use of pharmacologic substances for non-therapeutic purposes (H-470.994, H-470.972, H-470.978), it has not yet established a position regarding the various non-therapeutic applications and genetic manipulation of such technology; and
Whereas, our AMA-MSS has not adopted positions on either pharmacologic or genetic means of human enhancement; therefore be it

RESOLVED, that our AMA partners with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies; and be it further

RESOLVED, that our AMA partners with relevant institutions to develop and standardize detection strategies for performance enhancing, non-therapeutic gene therapies; and be it further

RESOLVED, that our AMA support endeavors to educate medical students, residents, and physicians regarding the current state of detection, counseling, and the potential adverse effects of non-therapeutic gene therapies; and be it further

RESOLVED, that our AMA-MSS formally support Non-Therapeutic Use of Pharmacological Agents by Athletes, H-470.994 and Medical and Nonmedical Uses of Anabolic-Androgenic Steroids H-470.972.

Fiscal Note: Significant, 11

Date Received: 9/20/17

References:


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

**Non-Therapeutic Use of Pharmacological Agents by Athletes H-470.994**
Our AMA: (1) opposes the use of drugs for the purpose of enhancing athletic performance or sustaining athletic achievement. This action in no way should be construed as limiting a physician's proper use of drugs in indicated treatment of athletic injuries or clinical symptoms of individual athletes; and (2) endorses efforts by state level high school athletic associations to establish programs which include enforceable guidelines concerning weight and body fat changes on a precompetition basis for those sports in which weight management is a concern.

**Medical and Nonmedical Uses of Anabolic-Androgenic Steroids H-470.972**
Our AMA (1) reaffirms its concern over the nonmedical use of drugs among athletes, its belief that drug use to enhance or sustain athletic performance is inappropriate, its commitment to cooperate with various other concerned organizations, and its support of appropriate education and rehabilitation programs; (2) actively encourages further research on short- and long-term health effects, and encourages reporting of suspected adverse effects to the FDA; and (3) supports continued efforts to work with sports organizations to increase understanding of health effects and to discourage use of steroids on this basis.

**Blood Doping H-470.978**
The AMA believes that a physician who participates in blood doping is deviating from his professional responsibility and that blood doping must be considered in the category of unnecessary medical services.

**Genome Editing and its Potential Clinical Use H-480.945**
Our AMA (1) encourages continued research into the therapeutic use of genome editing; and (2) urges continued development of consensus international principles, grounded in science and ethics, to determine permissible therapeutic applications of germline genome editing.
Whereas, The United States incarcerates more people than any other country on Earth;¹ and
Whereas, Bail serves as a collateral that defendants must pay to ensure they will appear in court after being released; and
Whereas, If the defendant cannot pay the bail set, he or she is detained in jail until trial; and
Whereas, More than two thirds of the 630,000 people currently in local jails are pretrial detainees, the majority of which are charged with nonviolent crimes and cannot afford to pay bail;² and
Whereas, Detainment in jail confers an increased risk for self harm and suicide, accounting for 35.3% of all jail deaths at a rate of 50 deaths per 100,000 people in 2014, compared to the general US population rate of 13 deaths per 100,000 people;³,⁴,⁵ and
Whereas, Infectious diseases such as tuberculosis, HIV/AIDS, hepatitis C, and common STDs are more prevalent in correctional facilities than the general US population, which increases the risk of transmission to both newly detained populations and the communities they re-enter upon release;⁶ and
Whereas, Sexual victimization was reported by 3.2% of jail inmates from 2011 to 2012, disproportionately affecting women in both staff-on-inmate and inmate-on-inmate victimizations;⁶,⁷ and
Whereas, 68% of people in jails have a substance use disorder, but less than 15% of those incarcerated receive appropriate treatment, increasing the likelihood of withdrawal while incarcerated as well as significantly increasing the likelihood of overdose upon release into the community;⁶,⁸ and
Whereas, 38 states in 2014 had policies to terminate Medicaid coverage when incarceration lasted for more than 30 days, leading to interruptions in coverage and healthcare; and

Whereas, Incarceration separates families, leading to disruptions in education, employment, and housing, all of which can perpetuate cycles of poverty; and

Whereas, Juvenile detention interrupts secondary education and has been shown to increase dropout rates after return to school; and

Whereas, According to a study surveying formerly incarcerated people and their families in 14 different states, 49% of families were unable to meet basic food needs and 48% had trouble meeting basic housing needs while their loved one was incarcerated; and

Whereas, Once detained, a defendant's time awaiting trial can exceed 3 years depending on where he or she lives; and

Whereas, Pretrial detainees were more likely to be convicted, less likely to have their charges reduced, and more likely to be sentenced to jail or prison than those who were not detained during the pretrial period; and

Whereas, Members of lower income communities and minorities are disproportionately detained, incarcerated, and subjected to the significant health risks outlined above because of their inability to pay bail, as 80% of those who cannot afford bail are in the poorest half of society; and

Whereas, Alternatives to money bail such as unsecured bonds, in which a defendant promises to pay a dollar amount only if he or she fails to appear at trial, have been shown to achieve equal levels of public safety and court appearance while shielding the individual from the aforementioned health risks of pretrial detention; and

Whereas, Pretrial detention costs state and local governments an estimated $13,600,000,000 each year; and

Whereas, Existing AMA-MSS policy “will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs” (270.029MSS); and

Whereas, Existing AMA policy “supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs” (H-95.931); therefore be it
RESOLVED, That the AMA work with lawmakers to support legislation that replaces money-bail with evidence based alternatives.

Fiscal Note: Significant, 10

Date Received: 9/20/17

References:

RELEVANT AMA AND AMA-MSS POLICY:

AMA Support for Justice Reinvestment Initiatives H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
AMA Support for Justice Reinvestments 270.029MSS
AMA-MSS will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs. (MSS Res 23, I-15) (AMA Res 205, A-16 Adopted as Amended [ ])

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 56
(I-17)

Introduced by: Justin Lee; Daniel Reiss; Sean O’Keefe; Daniel Li; Aravind Addepalli; Mehul Trivedi; Pratistha Koirala; Brian Lim; Alexis Corcoran, Albert Einstein College of Medicine

Subject: Non-Compete Clauses in Physician Contracts

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, There has recently been a growing movement towards physician employment by larger hospital-based groups\(^1,2\); and

Whereas, There exist non-compete clauses, or restrictive covenants, in physician employment contracts, which can impose a geographical restriction on physician practice after a physician leaves a group practice\(^3,4\); and

Whereas, Restrictive covenants can inhibit continuity of care and relationships between physicians and patients, resulting in a lower quality of care for the patient\(^4\); and

Whereas, Restrictive covenants have been shown to enable organizations to engage in monopolistic behaviors\(^4\); and

Whereas, Monopolistic behavior leads to higher prices placed on consumers, deadweight loss, and a decreased quantity of the good supplied\(^5\); and

Whereas, Consumers of healthcare in markets with a single hospital system were charged higher prices and had lower physician choice\(^6\); and

Whereas, Consumers of healthcare exhibit inelastic demand for healthcare services, meaning they bear the burden of increased prices\(^7\); and

Whereas, High prices of healthcare services lead to lower healthcare utilization rates for lower income patients, which is associated with negative health outcomes\(^8\); and

Whereas, Our AMA ethical opinions support high quality of health services, sufficient access to healthcare for all income levels and the lessening of financial obstacles to access healthcare (1.1.6) (11.1.4); and

Whereas, Consolidation of healthcare system, and the monopolization of geographic markets with the aid of restrictive covenants creates a geographic monopsony (a single buyer of services) in purchasing physician services, decreasing the bargaining power, geographic mobility, and market wage for physician labor\(^9\); and

Whereas, Consolidation of healthcare system, and the monopolization of geographic markets...
Whereas, Our AMA policy explicitly supports pluralism and fair market competition, which promotes fair bargaining, geographic mobility, and opposes markets from price-setting monopolies (H-385.990) (D-165.950); and

Whereas, Delaware, Colorado, Texas, Rhode Island, and Connecticut have existing legislation limiting the enforcement of non-compete clauses against physicians (6 DEL. CODE § 2707) (COLO. REV. STAT. § 8-2-113(3) (TEX. BUS. & COM.CODE § 15.50(b)-(c))\textsuperscript{10}; and

Whereas, Our AMA policy Physician-Hospital Relationships instills a mutual responsibility for physicians and hospital authorities to cooperate in effectively maintaining patient care and promoting the interests of patients (H-225.997); and

Whereas, Our AMA policy Hospital-Based Physician Contracting states that physicians have the right to set the parameters and acceptable terms for their contracts with managed care plans (H-383.997); and

Whereas, The Council of Ethical and Judicial Affairs (CEJA) has published official opinion regarding restrictive covenants, stating that these clauses may unreasonable restrict the right of a physician to practice medicine for a specified period of time or in a specific geographic area on termination of a contractual relationship (CEJA Report 3-A-14 (Opinion 11.2.3.1)); and

Whereas, Current Pursuant to AMA policy 'Principles for Graduate Medical Education' opposes that restrictive covenants must not be required of residents or applicants for residency education be required of residents or applicants for residency education, but does not extend this opposition to clauses in physician contracts (H-310.929); therefore be it

RESOLVED, That our AMA opposes the use of restrictive covenants in physician contracts and supports the passage of laws that prohibit their use.

Fiscal Note: Minimal, 5

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

Responsibilities of Physicians & Patients: Quality 1.1.6
As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable. While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:
(a) Keeping current with best care practices and maintaining professional competence.
(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
(c) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
(d) Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
(e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

Financial Barriers to Health Care Access 11.1.4
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation,

(a) Individual physicians should:
(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care. (c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services. (d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people. AMA Principles of Medical Ethics: I,II,VI,VII,IX

Payment for Physicians’ Services H-385.990
Our AMA:
(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.

(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.

(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.

(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.

Educating the American People About Health System Reform D-165.950
Our AMA will: (1) distribute our policy positions on health system reform to all declared candidates for the presidency of the United States of America and formally request their public support of those positions; (2) undertake a media campaign designed to educate the American people about AMA policy on health system reform, emphasizing pluralism, individual ownership of health insurance and the insurance market reforms necessary to allow free market principles to function; and (3) continue to use the Voice for the Uninsured campaign to advocate refundable, advanceable tax credits inversely related to income, with the goal of expanding health insurance coverage and choice, rather than to promote access to free clinics.

Physician-Hospital Relationships H-225.997
1. Physicians and hospital authorities have a mutual responsibility to cooperate and work together in effectively maintaining patient care.

2. Although final authority for granting, denial, termination, or limitation of hospital staff privileges is vested in the governing board of the hospital, it is expected that the judgment of the organized medical staff will be relied upon in the evaluation of the professional competence, education, experience, and qualifications of all physicians, including the hospital-associated medical specialists.

3. Physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it. They should be subject to the bylaws of the medical staff and conduct their professional activities according to the standards, rules and regulations adopted by it.

4. Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities for the purpose of improving patient care; providing continuing education for the benefit of the medical staff; and assisting in the training of physicians and allied health personnel. Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefore.
5. Hospitals are entitled to recover their reimbursable expenses, determined in accordance with recognized standard hospital cost-accounting principles, from the operation of departments in which hospital-associated medical specialists perform personally or supervise or direct the services provided patients.

6. The form of the contractual or financial arrangement between hospitals and hospital-associated physicians depends upon the facts and practical considerations existing in each situation. No single form of contractual or financial arrangement can be feasible for all of the arrangements that may be entered into between hospitals and hospital-associated physicians. The essential consideration is that whatever the arrangement, it is fair to the parties, promotes the interests of patients and supports the provision of high quality care and services. Arrangements should be avoided that are unrelated to the professional services, or time expended or to the skill, education, and professional expertise of the physician, and that result in disproportionate earnings.

7. Hospital-associated medical specialists are entitled to charge (a) for the services they provide in accordance with the same standards of equity and fairness that apply to the charges of other physicians, and (b) for supervision of personnel under their direction.

8. There should be no duplication of charges to the patient where services are not actually provided by both the physician and the hospital. Each party should receive the compensation reasonably and equitably owing for services for which each is primarily responsible. Only one of the parties is entitled to the reasonable costs of assuring the accuracy and reliability of the procedures performed in such departments.

9. Both hospitals and hospital-associated medical specialists have an obligation to serve the needs of patients and the medical staff. The primary responsibility for determining the services needed adequately to care for the needs of individual patients should be that of the attending physician subject to review by his peers.

Hospital-Based Physician Contracting H-383.997

(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations.
(b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations.
(c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty.
(d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably.
(e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination.
(f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks.
(g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments.
(h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price.

(i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting.

(j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation.

(k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.

(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

(3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals.

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must
be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

CEJA Report 3-A-14 (Opinion 11.2.3.1)

Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms. Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:

(a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and

(b) Do not make reasonable accommodation for patients’ choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.
Whereas, Over 20 million Americans ages 12 and older have a substance use disorder (SUD),
and annual drug overdose deaths have grown to nearly 65,000 in the United States;¹,²,³ and

Whereas, Only 17 percent of American adults in need of substance use treatment receive it;⁴ and

Whereas, Privacy concerns are a major barrier to those in need of but not receiving substance
use treatment, with 8 percent expressing concern that neighbors or their community would have
a negative opinion, 10 percent not wanting others to find out, and 16 percent expressing
concern for their jobs;⁴ and

Whereas, Federal regulations at 42 CFR Part 2 ("Part 2"), titled "Confidentiality of Substance
Use Disorder Patient Records," and their authorizing statute, Title 42, U.S.C. 290dd-2, apply to
the records of patients treated by federally assisted SUD programs;⁵ and

Whereas, The express purpose of Part 2 is to ensure that people with SUDs are not made more
vulnerable by the availability of their records, due to potential consequences for employment,
housing, child custody, discrimination by insurers and medical professionals, and criminal
justice system involvement;⁵ and

Whereas, Part 2 requires written consent for nearly all disclosures of SUD treatment and
diagnosis information, with exceptions under limited circumstances, e.g., in medical
emergencies or under court order and subpoena;⁶ and

Whereas, The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule
provides less stringent protections than Part 2, and allows covered entities to use and disclose
protected health information without authorization (or written consent) to other covered entities
for the purposes of treatment, payment, and health care operations (TPO);⁸ and

Whereas, The recently reintroduced Overdose Prevention and Patient Safety Act, would remove
Part 2’s consent requirement for disclosures related to TPO, while prohibiting criminal charges
or investigations based on such disclosures;⁷ and

Whereas, The President’s Commission on Combating Drug Addiction and the Opioid Crisis
endorsed the Overdose Prevention and Patient Safety Act in its Draft Interim Report, and the
American Psychiatric Association and the American Society of Addiction Medicine have expressed their support for the bill,\textsuperscript{8,9} and

Whereas, Our AMA’s advocacy team reported about a 2017 revision to the Part 2 rule that “the AMA agreed with [the Substance Abuse and Mental Health Services Administration’s] goal of enabling patients with substance use disorders to benefit from new integrated health care models without exposing them to adverse consequences that could act as a deterrent to their seeking needed care”,\textsuperscript{10} and

Whereas, Existing AMA policy and conversations with SAMHSA address the question of whether opioid treatment programs may report to prescription drug monitoring programs under Part 2, but not the larger question of the impact of Part 2 on patient outcomes and privacy, or our AMA’s support for or opposition to changes;\textsuperscript{11,12} and

Whereas, Patients with SUDs disproportionately suffer from many medical comorbidities, particularly in patients with co-occurring mental illness, that may require treatment by physicians who are not their SUD treatment providers but whose clinical decision making could be impacted by knowledge of patients’ SUD diagnosis or treatment;\textsuperscript{13,14,15,16} and

Whereas, One study demonstrated that even with patients’ consent for disclosure of SUD records to primary care providers, medical records showed inconsistent documentation of SUD information and potential medication interactions for patients on methadone maintenance therapy, suggestive of potential harm due to fragmented information sharing among providers;\textsuperscript{17} and

Whereas, In a 2017 survey of U.S. employers, 71 percent agreed that misuse and abuse of prescription drugs is a disease that should be treated like any chronic health condition, but 65 percent agreed that it is a justifiable reason to fire an employee, and 25 percent reported drug testing employees for methadone, suggestive of potential adverse employment consequences for patients known to be in SUD treatment;\textsuperscript{18} and

Whereas, Proponents of aligning SUD record protections with HIPAA cite improved care integration and coordination, avoidance of patient harm due to non-disclosure, and de-stigmatization of SUD diagnosis and treatment as potential benefits, largely with anecdotal evidence;\textsuperscript{19,20} and

Whereas, Opponents of aligning SUD record protections with HIPAA cite continued stigmatization and social and legal consequences as potential drawbacks, largely with anecdotal evidence;\textsuperscript{21,22} therefore be it

RESOLVED, That our AMA study the implications of 42 CFR Part 2 under current law, as well as the proposed alignment of substance use disorder confidentiality requirements with HIPAA, with respect to:

1) harm due to unwanted disclosure of Substance Use Disorder (SUD) diagnosis and treatment information, including legal, social, emotional, and psychological outcomes;

2) harm due to non-disclosure of Substance Use Disorder (SUD) diagnosis and treatment information to other health care providers; and

3) Deterrence of patients from seeking treatment for SUDs.
Fiscal Note: Moderate, 9

Date Received: 9/20/17

References:


11. Opioid Treatment and Prescription Drug Monitoring Programs D-95.980.


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

**Patient Confidentiality and Government Investigations 315.001MSS**
AMA-MSS opposes the implementation of federal legislation that would enable any government agency or representative of such agency to access a patient’s medical records without the patient’s knowledge and consent or court order. (MSS Amended Sub Res 11, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

**Recognition of Addiction as Pathology, Not Criminality 95.005MSS**
AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16)

**Patient Privacy and Confidentiality H-315.983**
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients’ privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong
countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients’ privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients’ informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients’ medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients’ medical information. (d) A patient’s ability to join or a physician’s participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any
other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

**HIPAA Law And Regulations D-190.989**

(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.

(2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.

(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.

(4) Our AMA shall immediately begin working with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act so as to reduce the fiscal burden on physicians.

**HIPAA Privacy Regulations Implementation D-190.992**

Our AMA shall continue to make it an urgent priority to undertake a comprehensive review including unfunded physicians costs of implementation of HIPAA transaction, privacy and security rules to identify provisions that should be clarified, improved or repealed and communicate there urgently needed changes to the Department of Health and Human Services and Congress for prompt action, including any necessary delays in implementation, as appropriate.

**HIPAA D-190.984**

Our AMA continue to identify and work toward the repeal of the onerous provisions in the Health Insurance Portability and Accountability Act legislation and regulations, including its criminal liability provisions, and that our AMA work to redress the breaches of patient confidentiality that the HIPAA regulations have allowed.

**Prescription Drug Diversion, Misuse and Addiction H-95.945**

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other
so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

**Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947**

Our AMA:

1. supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
2. policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
3. actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
4. encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
5. advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
6. will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
7. will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
8. will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
9. will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

**Informed Consent and Decision-Making in Health Care H-140.989**

1. Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

2. Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being "a part of the solution" to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

**Opioid Treatment and Prescription Drug Monitoring Programs D-95.980**

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.
Introduced by: Neil Jairath, University of Michigan Medical School, Samuel Schuiteman, Michael Broderick, Apoorv Dhir, University of Michigan Medical School

Subject: Procedural Outcome Transparency and Reporting Standardization Across Healthcare Providers

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Transparent reporting of the performance of the health care system is often promoted as a key tool for improving the value of health care by improving quality and lowering costs;¹ ² ³ ⁴

Whereas, Transparency can improve value by two key pathways, including informing providers about their performance and encouraging them to match the level of their peers and by allowing consumers to choose a provider that best fits their needs;⁵ and

Whereas, It is useful for patients, clinicians, payers, and purchasers to have measures of absolute and relative performance to facilitate informed choice of providers, innovative benefit designs, and provider networks, and alternative payment methods that support quality improvement and greater affordability;⁶ and

Whereas, Small successes exist in public reporting that drive improved performance,⁷ including the reporting of the Society of Thoracic Surgeons registries in cardiac surgery,⁸ ⁹ ¹⁰ the CDC’s measures of health care-associated infections,¹¹ ¹² measures of diabetes-care processes,¹³ ¹⁴ intermediate outcomes, and complications,¹⁵ and the Agency for Healthcare Research and Quality’s Hospital Consumer Assessment of Healthcare Providers and Systems measure;¹⁶ ¹⁷ and

Whereas, Health care organizations and providers frequently invest time and energy to improve their performance on reported measures;¹⁸ and

Whereas, Increasing transparency in procedural outcomes would empower patients to choose their health care provider that best fits their needs, and existing AMA policy already states that individuals should be able to freely choose their physician and/or system of health care (H-373.998); and

Whereas, the AMA already supports price and quality transparency for patients and physicians (D-155.987); and

Whereas, Existing AMA and AMA-MSS policies support increased outcomes research for educational purposes, promoting the use of outcomes research in the development of practice parameters, and including favorable outcome as one measure of medical care of high quality consistent with the best interests of the patient (H-450.973, H-450.995); and

Whereas, Medicare is already publishing hospital outcomes data through their Hospital Compare Program, making certain outcomes data publicly available by hospital;¹⁹ and
Whereas, The variety of measures and methods used to measure performance could be a product of different underlying hypotheses and biases, for example Consumer Reports and the Leapfrog Group both issue patient-safety composites for hospitals, with the two organizations choosing to define safety differently (Leapfrog as “freedom from harm” and Consumer Reports as “a hospital’s commitment to the safety of its patients”) to reflect their chosen definition of the construct; therefore be it

RESOLVED, That our AMA support validating the reported measures being acted upon by health care organizations and providers by reaffirming existing policy H-450.966; and be it further

RESOLVED, That our AMA support building the science of performance measures through encouraging the multiple federal agencies involved in performance measures to collaborate and consolidate their reporting standards; and be it further

RESOLVED, That our AMA support the accreditation of a standardized reporting service (reporting body) or reporting rubric (guideline) to measure hospitals’ performance; and be it further

RESOLVED, That our AMA collaborate with health care institutions to make available to the public the outcomes data collected as a part of the rigorous research processes previously supported in AMA policy and advocated for in this resolution.

Fiscal Note: Moderate, 10

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:
H-450.995 Quality of Care – Essentials and Guidelines for Quality Assessment
The AMA supports tracking patient outcomes as a way to improve continuity of care and to best support

(1) Supports Including favorable outcome as one characteristic, the AMA believes that medical care of high quality should: (a) produce the optimal possible improvement in the patient's physiologic status, physical function, emotional and intellectual performance and comfort at the earliest time possible consistent with the best interests of the patient; (b) emphasize the promotion of health, the prevention of disease or disability, and the early detection and treatment of such conditions; (c) be provided in a timely manner, without either undue delay in initiation of care, inappropriate curtailment or discontinuity, or unnecessary prolongation of such care; (d) seek to achieve the informed cooperation and participation of the patient in the care process and in decisions concerning that process; (e) be based on accepted principles of medical science and the proficient use of appropriate technological and professional resources; (f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare; (g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and (h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.

(2) The AMA believes that the following guidelines for quality assessment should be incorporated into any peer review system. (a) The criteria utilized to assess the degree to which medical care exhibits the essential elements of quality should be developed and concurred in by the professionals whose performance will be reviewed. (b) Such criteria can be derived from any one of the three basic variables of care: structure, process, or outcome. However, emphasis in the review process should be on statistically verifying linkages between specific elements of structure and process, and favorable outcomes, rather than on isolated examination of each variable. (c) To better isolate the effects of structure and process on outcome, outcome studies should be conducted on a prospective as well as a retrospective basis to the degree possible. (d) The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in quality assessment. (e) Blanket review of all medical care provided is neither practical nor needed to assure high quality of care. Review can be conducted on a targeted basis, a sampling basis, or a combination of both, depending on the goals of the review process. However, judgment as to performance of specific practitioners should be based on assessment of overall practice patterns, rather than solely on examination of single or isolated cases. By contrast, when general assessment of the quality of care provided by a given health care system or across systems is desired, random sampling of all care episodes may be the more appropriate approach. (f) Both explicit and implicit criteria are useful in assessing the quality of care. (g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment. (h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance. (i) The quality assessment process itself should be subject to continued evaluation and modification as needed.
H-373.998 Patient Information and Choice

The AMA supports giving individuals freedom in choosing a physician and/or system of health care delivery, and that prices of care should be made readily available to individuals before the provision of care. The AMA believes that efforts should be made that improve the ability of patients to make choices that best fit their needs, and that providing information to patients is an important part of a market-driven health care system (Reaffirmed: Res. 108, A-17).

D-155.987 Price Transparency

The AMA encourages physicians to communicate health care pricing information to their patients, recognizing that the cost of health care is an important part of choosing where and how to receive health care (CMS Rep. 4, A-15 Reaffirmed in lieu of: Res. 121, A-16).

H-450.966 Quality Management

The AMA:

(1) continues to advocate for quality management provisions that are consistent with AMA policy;

(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;

(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;

(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;

(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and

(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and
measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

**H-450.994 Quality Assurance in Health Care**

(1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94)

(2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various healthcare professions within the facility.

(3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality of care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise.

(4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers.

(5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and in continuing education programs.

(6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality.

(7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care.
Whereas, Low-income adults who qualify for Medicaid bear the greatest burden of chronic diseases, including diabetes mellitus, cardiovascular disease, and obesity;¹ and

Whereas, Major risk factors for chronic diseases, including physical inactivity, are disproportionately associated with low socioeconomic status;²,³ and

Whereas, Forty-two percent of Americans today live with multiple chronic conditions, constituting over 70 percent of all healthcare spending in the United States;⁴,⁵,⁶ and

Whereas, For every dollar spent on Medicaid, 83 cents go towards the treatment of chronic diseases;⁷ and

Whereas, The frequency of fitness center visits has been shown to be directly correlated with monthly healthcare savings;⁸ and

Whereas, Existing AMA policies urge the development of exercise programs targeted to individuals over 65 and under 18, but non-elderly adults living in poverty have limited access to basic fitness facilities (H-25.995, H-470.961, H-470.975, H-470.989, H-470.998, H-470.999); and

Whereas, Existing AMA, MSS, and HOD policies call upon physicians to promote physical fitness to the general public and encourage funding of community exercise venues in order to reduce incidence of chronic illness (H-470.990, H-470.991, H-470.997, 440.021MSS, D-470.993, 440.018MSS); and

Whereas, In contrast to private fitness facilities, community-based recreational exercise spaces are often pedestrian-unfriendly, unsafe, or inaccessible, leading to their underutilization;⁹ and

Whereas, Cost is a major barrier to attaining fitness facility memberships, particularly for families eligible for Medicaid;¹⁰,¹¹ and

Whereas, In a survey of low-income adults at risk for chronic disease, fitness facility memberships were rated as the most helpful amongst insurance-provided wellness benefits;¹² and
Whereas, Fitness facility memberships alone yielded similarly effective improvements in chronic illness-related risk factors, in comparison to more costly comprehensive wellness programs that added nutritional education and personal fitness trainers; therefore be it RESOLVED, That our AMA support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for low-income adults; and be it further RESOLVED, That our AMA collaborate with physicians, hospital systems, insurers, and other allied health professionals, to promote the expansion of Medicaid coverage to include fitness facility memberships.

Fiscal Note: Moderate, 10

Date Received:

References:

12. Jarlenski MP, Gudzune KA, Bennett WL, Cooper LA, Bleich SN. Insurance Coverage for
and Depressive Symptoms Among People With Serious Mental Illness. Journal of
Nervous and Mental Disease. 2017; 205(8):634-640.

RELEVANT AMA AND AMA-MSS POLICY:

Promotion of Exercise Within Medicine and Society H-470.990
Our AMA supports:

(1) education of the profession on exercise, including instruction on the role of exercise
prescription in medical practice in its continuing education courses and conferences, whenever
feasible and appropriate;

(2) medical student instruction on the prescription of exercise;

(3) physical education instruction in the school system; and

(4) education of the public on the benefits of exercise, through its public relations program.

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant
cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients
and to shape programs to meet each patient's capabilities and level of interest.

2. Our AMA supports National Bike to Work Day and encourages active transportation
whenever possible.

Exercise and Physical Fitness H-470.997
The AMA encourages all physicians to utilize the health potentialities of exercise for their
patients as a most important part of health promotion and rehabilitation, and urges state and
local medical societies to emphasize through all available channels the need for physical activity
for all age groups and both sexes. The AMA encourages other organizations and agencies to
join with the Association in promoting physical fitness through all appropriate means.

Promoting Fitness and Healthy Lifestyles 440.021MSS
AMA-MSS encourage all physicians and health professionals to set an example by (1) striving
to maintain a healthy weight and engaging in physical activity as recommended by scientific
literature and expert panels; (2) maintaining a healthy and nutritious diet as recommended by
scientific literature and expert panels; and (3) getting enough sleep to avoid the known short
and long term adverse effects of sleep deprivation as recommended by scientific literature and
expert panels.

Government to Support Community Exercise Venues D-470.993
Our AMA will encourage: (1) towns, cities and counties across the country to make recreational
exercise more available by utilizing existing or building walking paths, bicycle trails, swimming
pools, beaches and community recreational fitness facilities; and (2) governmental incentives
such as tax breaks and grants for the development of community recreational fitness facilities.
Childhood Obesity as a Public Health Epidemic 440.018MSS
AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups.

Exercise Programs for the Elderly H-25.995
The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients’ exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program.

Requirement for Daily Free Play in Schools H-470.961
Our AMA recommends that elementary schools maintain at least thirty minutes of daily free play or physical education that is consistent with CDC guidelines.

Mandatory Physical Education H-470.975
The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes.

Physical Fitness and Physical Education H-470.989
Our AMA: (1) urges school boards, administrators and parents to provide physical education programs during elementary, junior high and senior high years; and (2) stresses that these programs be conducted by qualified personnel, be designed to teach health habits and physical skills, and be designed to instill a desire in the student for physical fitness that will carry over into adult life.

Youth Physical Fitness H-470.998
The AMA and its state and local components should reemphasize their support of local school and college youth fitness programs.

Youth Fitness H-470.999
Our AMA: (1) approves in principle the aims and objectives of the President’s Council on Fitness, Sports, and Nutrition and urges its member physicians to cooperate in the promotion of properly developed and soundly conceived plans and programs for youth fitness; and (2) requests the constituent associations and their member local medical societies to work cooperatively with reputable professional and other ethical groups interested in the improvement of youth fitness.
Resolution: 60
(I-17)

Introduced by: Max Blumberg, Moudi Hubeishy, Mattie Rosi-Schumacher, Henry Greyner-Almeida, Kelly Coughlin, Anisha Chava, Bradley Frate, Emily Benton, SUNY Buffalo

Subject: Addressing the Rise of Medical School Tuition

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Medical student debt has been reported as high as $350,000, with the average indebtedness of a graduating medical student in 2016 at $189,165, a 65% increase since 2004; and

Whereas, Policy efforts to improve physician workforce diversity and mitigate shortages in the primary care workforce are inhibited by rising levels of medical student tuition and subsequent indebtedness; and

Whereas, Greater educational debt is associated with decreased career satisfaction, negative effects on personal work-life balance, and burnout; and

Whereas, Since the 2008 recession, state funding for public universities has drastically declined, resulting in higher medical school tuition in order to balance university budgets; and

Whereas, Our AMA Council on Medical Education most recently studied strategies to limit student debt in 2004; and

Whereas, Medical school tuition has dramatically increased since 2004 - the average medical school tuition in 2004-2005 was $14,296/$32,245 (public/private) vs. the average medical school tuition in 2016-2017 was $30,053/$50,599 (public/private); and

Whereas, Levels of indebtedness have increased far more than inflation and physician compensation; therefore be it

RESOLVED, That our AMA study potential solutions to limit the drastic rise in medical school tuition.

Fiscal Note: Minimal, 6

References:

1. AAMC Medical Student Education Debt, Costs, and Loan Repayment Fact Card


25. AAMC Tuition and Student Fees Reports https://www.aamc.org/data/tuitionandstudentfees/

RELEVANT AMA AND AMA-MSS POLICY:

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.

Medical School Financing, Tuition, and Student Debt D-305.993
1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.
2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.
3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
5. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
6. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial
planning/debt management for use by medical students, resident physicians, and young physicians.

7. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Financial obligations, such as repayment of loans, and service obligations made in exchange for financial assistance, should be fulfilled. There should be mechanisms to assist physicians who are experiencing hardship in meeting these obligations.

10. Our AMA supports the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

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

Medical School Admission Policies 305.004MSS
AMA-MSS will ask the AMA to: (1) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (2) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and of the sources of financial aid available; and (3) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.

Preservation of Manageable Tuition Rates Through Medical School Financial Assistance 305.006MSS
AMA-MSS will ask the AMA to encourage state medical societies to support the introduction of legislation that would increase state subsidies to public and private medical schools within their states.

Medical School Tuition 305.010MSS
AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class.

Medical School Tuition 305.037MSS
The AMA-MSS Governing Council will continue to work with AMA staff to ensure student concerns on indebtedness and medical school tuition are addressed in all health system reform legislation.
WHEREAS, Many physicians are reluctant to adopt the use of Electronic Medical Records (EMRs) due to perceived security and confidentiality risks; and

WHEREAS, Incidence of cyber-attacks on hospital systems has increased in recent years; and

WHEREAS, Frequency of cybersecurity breaches due to poor use of private email, firewalls, and other basic security measures remains high; and

WHEREAS, More than 500,000 affected patients whose EMRs have been breached within the past two years still under active investigation by the Office for Civil Rights; and

WHEREAS, The Hollywood Presbyterian Medical Center paid $17,000 to obtain the decryption key after a ransomware attack in February 2016; and

WHEREAS, According to the Federal Bureau of Investigation (FBI), more than $209 million have been lost as ransomware payments in the United States from January to March of 2016, and $25 million for 2015; and

WHEREAS, The FBI recommends prevention efforts including awareness training for employees, robust technical prevention controls, and solid business continuity plan in the event of a ransomware attack; and

WHEREAS, According to the 2016 Healthcare Information and Management Systems Society (HIMSS) Cybersecurity Study, firewalls are a basic component of network security, but only 78.2% of acute care providers 90.3% of non-acute care providers use them, making for a total use of 80.7% use across healthcare systems; and

WHEREAS, A 2016 HIMSS Cybersecurity Study reports 80% of surveyed providers have recently experienced a "significant security incident," but due to the sensitive nature of information on data breaches, these numbers may be under-representing the true extent of the issue; be it therefore

RESOLVED, that our AMA-MSS support EMR cybersecurity training for all healthcare employees during EMR-onboarding to prevent breach of health and financial records; and be it further
RESOLVED, that our AMA-MSS support the universal use of anti-virus, anti-malware, firewall protection, encryption of data at rest and in transit, and accountability through audit logs of all patient health information and financial records.

Fiscal Note: Minimal, 4

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

- Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973
  - All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
  - The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
• National Health Information Technology D-478.995
  o 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
  o 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
  o 3. Our AMA will request that the Centers for Medicare &; Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
  o 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
  o 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.
  o 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
  o 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
  o 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

• Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977
  o Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.

• Improving Cybersecurity in Healthcare Facilities - 315.006MSS
  o RESOLVED, That our AMA-MSS support the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge.
3.3.3 Breach of Security in Electronic Medical Records

- When used with appropriate attention to security, electronic medical records (EMRs) promise numerous benefits for quality clinical care and health-related research. However, when a security breach occurs, patients may face physical, emotional, and dignitary harms.
- Dedication to upholding trust in the patient-physician relationship, to preventing harms to patients, and to respecting patients' privacy and autonomy create responsibilities for individual physicians, medical practices, and health care institutions when patient information is inappropriately disclosed.
- The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on his or her awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.
- When there is reason to believe that patients' confidentiality has been compromised by a breach of the electronic medical record, physicians should:
  - (a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose.
  - (b) Follow all applicable state and federal laws regarding disclosure.
  - (c) Physicians have a responsibility to follow ethically appropriate procedures for disclosure, which should at minimum include:
    - Carrying out the disclosure confidentially and within a time frame that provides patients ample opportunity to take steps to minimize potential adverse consequences.
    - Describing what information was breached; how the breach happened; what the consequences may be; what corrective actions have been taken by the physician, practice, or institution; and what steps patients themselves might take to minimize adverse consequences.
  - (e) Supporting responses to security breaches that place the interests of patients above those of the physician, medical practice, or institution.
  - (f) Providing information to patients to enable them to mitigate potential adverse consequences of inappropriate disclosure of their personal health information to the extent possible.
Whereas, Numerous studies have demonstrated the widespread existence of sex and gender bias and disparities in the provision and outcomes of health care, and that awareness of gender bias does not negate its effect; and

Whereas, The World Health Organization (WHO) defines health inequity or disparity as “differences in health, which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust;” and

Whereas, These disparities have been attributed to provider bias, physiologic and pathophysiologic sex differences, or a combination of both; and

Whereas, It has been shown that patients with a feminine gender identity or presentation are at risk for gender-bias in health care regardless of biological sex; and

Whereas, There exist gender disparities in referral patterns and wait times for orthopedic surgery, with evidence of women waiting longer for surgery from time of injury (20 vs. 14 months) and having worse pain and disability at the time of surgery; and

Whereas, Women more often receive suboptimal cardiac care and have worse outcomes than men, including fewer pharmacologic and invasive therapies, longer wait times for interventions (door to ST-segment elevated myocardial infarction (STEMI) activation time of 25.5 minutes for women vs. 18.5 minutes for men), and higher myocardial infarction mortality rates, and were more likely to exceed guideline times for percutaneous coronary intervention (PCI) than men (41% versus 29%); and

Whereas, A recent study of a PCI-based STEMI system using a standardized STEMI protocol showed diminished treatment disparities between men and women; and

Whereas, Utilization of a clinical decision support (CDS) tool increased prescription of venous thromboembolism prophylaxis (VTE) from 76.4% to 95.6% and completely eliminated the incidence of preventable VTE at Johns Hopkins Hospital; and

Whereas, Prior to utilizing a CDS tool, female trauma patients were prescribed appropriate VTE prophylaxis significantly less often than male patients (55.1% vs. 69.5%); and
Whereas, CDS has been shown to eliminate significant differences in the appropriate prescription of VTE prophylaxis prescription for male (85.7%) and female (81.2%) patients;\textsuperscript{15} and

Whereas, The VTE prophylaxis study at John Hopkins has been credited in the journal Critical Care Nurse as a promising method to reduce gender bias,\textsuperscript{18} and has been recognized by the Journal of the American College of Surgeons as a possible new strategy to reduce gender disparities;\textsuperscript{10} and

Whereas, A study of STEMI treatment following a protocol showed fewer race disparities in outcomes compared to non-STEMI treatment without a protocol, indicating that implementation of standardized treatment protocols can help diminish health care disparities;\textsuperscript{11} and

Whereas, In 2014 the American Heart Association and American Stroke Association released a clinical guide on stroke prevention that included topics specific to women;\textsuperscript{14} and

Whereas, It has been suggested that professional society guideline-based cardiac resynchronization recommendations should be updated to be specific for men or women;\textsuperscript{19} and

Whereas, The AMA’s Commission to End Health Care Disparities sought “to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor;” yet conclusions from the Commission refer only to racial and ethnic disparities;\textsuperscript{20} and

Whereas, The Council on Ethical and Judicial Affairs of the American Medical Association published recommendations in 1991 that “procedures and techniques that preclude or minimize the possibility of gender bias should be developed and implemented,”\textsuperscript{21} yet gender disparities persist in health care; and

Whereas, A 2016 report from the AMA’s Council on Science and Public Health acknowledged both biological and social factors leading to disparities in women’s health, but only suggested improving medical education and including women in clinical research as solutions;\textsuperscript{22} and

Whereas, The resulting opinions of the 2015 NIH-ACS Summit on Surgical Disparities Research challenged researchers to identify interventions that may mitigate gender-based surgical disparities, prioritize systematic evaluation of health technologies in research to reduce disparities, and to “begin moving research in the field of surgical disparities from knowing to doing;\textsuperscript{23} and

Whereas, The AMA has existing policy declaring a commitment to eliminating health care disparities with a specific mention of racial and ethnic health disparities, but does not have a policy directly targeting gender-based health care disparities;\textsuperscript{20} therefore be it

RESOLVED, That our AMA promotes the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and
RESOLVED, That our AMA encourages the use of guidelines and treatment protocols specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes; and be it further

RESOLVED, That our AMA supports the use of gender-neutral decision support tools that aim to mitigate gender bias in diagnosis and treatment.

Fiscal note: Significant, 10

Date received:

References:

RELEVANT AMA ANDAMA-MSS POLICY:

D-478.995 National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare and Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

H-350.971 AMA Initiatives Regarding Minorities
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following...
components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

D-350.995 Reducing Racial and Ethnic Disparities in Health Care

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) **Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.**

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Support of Human Rights and Freedom H-65.965

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

An Expanded Definition of Women's Health H-525.976

Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

Medical Education and Training in Women's Health H-295.890
Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women's health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served; (4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training; (5) encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs; (6) encourages physicians to include continuing education in women's health/gender based biology as part of their continuing professional development; and (7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the various Residency Review Committees to promote attention to women's health in accreditation standards.

Sex and Gender Differences in Medical Research H-525.988
Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies’ impact on the health care of society at large; (2) affirms the need to include both genders in studies that involve the health of society at large and publicize its policies; (3) supports increased funding into areas of women's health research; (4) supports increased research on women's health and participation of women in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based analysis of data, even if such comparisons are negative.

8.5 Disparities in Health Care

Topic: OPINIONS ON PHYSICIANS & THE HEALTH OF THE COMMUNITY

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

(a) Provide care that meets patient needs and respects patient preferences.

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.

(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

**Principles of the Patient-Centered Medical Home H-160.919**

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

**Principles**

**Personal Physician** - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician Directed Medical Practice** - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole Person Orientation** - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other
qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

**Evidence-based medicine and clinical decision-support tools guide decision making.**

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

**Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.**

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

**Medicare Physician Payment Reform D-390.961**

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.

2. **Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.**

3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.

4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.

5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.

**Relevant AMA-MSS Policy:**

**295.181MSS**

Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum: AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H-295.874])
Whereas, Transgender or gender nonconforming (TGNC) patients face significant health disparities, such as in communicable diseases, mental health, and substance use disorders;\(^1,2\) and

Whereas, TGNC patients also face barriers to health care, through social stigma, lack of culturally competent providers, inappropriate provider behavior, or unfamiliarity with transgender medicine;\(^3,4\) and

Whereas, Estimates show that about 1 million adults in the United States, or about 0.3 percent of the total population, identify as transgender—many of whom interact with the health care system;\(^5\) and

Whereas, In H-65.964 Access to Basic Human Services for Transgender Individuals, the AMA opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and

Whereas, In H-160.991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations, the AMA believes that the physician's nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness; and

Whereas, To be more inclusive of gender identity (GI), in H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation the AMA supports a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and

Whereas, In 2015, Stage 3 of Meaningful Use guidelines by the Centers for Medicare & Medicaid Services instructed functionality to record GI in EHR systems;\(^6,7,8,9\) and

Whereas, While the inclusion of GI has provided positive results in data collection and recognition of patient preferences, GI in the EHR is still often missed or misinterpreted during patient encounters;\(^7\) and

Whereas, One of the main criticisms of GI in the EHR is that it is not readily available or prominently displayed during patient encounters;\(^6,7,10\) and
Whereas, These misinterpretations or lapses in culturally competent care may serve as continued barriers to health care;

Whereas, the World Professional Association for Transgender Health recommends that EHRs should contain a method to “notify providers and clinic staff of a patient’s preferred name and/or pronoun;” therefore be it RESOLVED, That our AMA amend policy H-315.967 by addition:

Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health; and (3) supports that, with patient consent, gender identity be prominently displayed and easily accessible within the electronic health record.

Fiscal Note: Minimal, 5

Date Received: 9/20/17

References:


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

**Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967**

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

**Access to Basic Human Services for Transgender Individuals H-65.964**

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

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

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

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

**Support of Human Rights and Freedom H-65.965**

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

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

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

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

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

65.019MSS
Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients: AMA-MSS supports (1) policies that reduce barriers to and allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a health care provider that the individual is undergoing or has undergone gender transition according to applicable medical standards of care; and (2) that sex designation on an individual’s birth certificate, or any change thereof, not hinder access to appropriate medical care. (MSS Res 12, I-13)
Whereas, Tetrahydrocannabinol (THC) is the primary psychoactive substance found in marijuana products, while Cannabidiol (CBD) is a chemically distinct compound found in marijuana products with no known psychoactive effects; and

Whereas, CBD is not addictive and has proven to produce anxiolytic, antipsychotic, antidepressant, and neuroproductive effects specifically, patients from the age of 1-30 years with treatment resistant epilepsy had a 36.5% reduction in monthly motor seizures over a 12 week treatment period with cannabidiol with an adequate safety profile and

Whereas CBD is effective in pain management with minimal side effects, particularly in cases of multiple sclerosis and intractable cancer pain, and has been approved as a pain medication in Canada for both conditions, as well as having documented positive impacts on many neural circuits linked to addiction and drug-seeking behaviors, making it a potentially effective treatment for substance abuse disorders without significant side effects; and

Whereas, In 2016 the U.S. Food and Drug Administration granted Orphan Drug status to GW Pharmaceuticals for Epidiolex® (cannabidiol) for the treatment of Tuberous Sclerosis Complex; and

Whereas, The DEA has established a new drug code for marijuana extracts that moves all extracts “containing one or more cannabinoids that has been derived from any plant of the genus Cannabis, other than the separated resin (whether crude or purified) obtained from the plant” to a Schedule 1 drug (including CBD). DEA Schedule I drugs are defined as those with no accepted medical benefits, a high potential for abuse, or those that are not considered safe for human consumption, and Schedule 1 substances cannot be prescribed and can only be administered under federally approved research programs; and

Whereas, Moving CBD to a Schedule 1 drug removes its availability to patients benefiting from these effects in states without medical marijuana and significantly slows medical research in CBD trials; and
Whereas, The Justice Department has stalled new research proposals for medical marijuana and has asked Congress to block statutory medical marijuana protections with new appropriations language, while pursuing criminal prosecution for individuals using marijuana; and

Whereas, The non-psychoactive, non-addictive properties of Cannabidiol would address the stated concerns of The Justice Department regarding psychoactive drug use and abuse potential; therefore be it

RESOLVED, That our AMA advocate against the classification of Cannabidiol (CBD) as a Schedule 1 drug.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

95.003MSS Marijuana: Medical Use and Research
AMA-MSS will ask the AMA to support reclassification of marijuana’s status as a Schedule I controlled substance into a more appropriate schedule. (MSS Res 2, A-08) (AMA Res 910, I-08 Referred) (Reaffirmed: GC Rep B, I-13)

370.014MSS Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant
AMA-MSS opposes utilization of 1) reported marijuana use; and 2) positive cannabis toxicology tests as a relative contraindication for potential organ transplant recipients. (MSS Late Res 3, I-14)

D-95.976 Cannabis - Expanded AMA Advocacy
1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available.
2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research.
3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a “public health”, as contrasted with a “criminal,” approach to cannabis.
4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."

H-95.952 Cannabis for Medicinal Use
(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods.
This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.
Whereas, Recent evidence suggests that as many as 760,000 high school athlete concussions may go unreported in the United States each year (J Kahan, MD, unpublished data, June 2017); and

Whereas, Several studies have demonstrated that player knowledge of concussions is an important predictor of concussion reporting, with well-informed players being more likely to report suffering a head injury during play14; and

Whereas, Further research also suggests that improving player perception of concussion reporting may increase reporting rates, as players with negative perceptions of reporting (i.e. fear of missing play, stigma of reporting or suffering a head injury, etc.) are less likely to self-report a suspected head injury2,3,5-7; and

Whereas, Player perception of reporting is never mentioned in the current AMA policy finder or AMA recent digests; and

Whereas, Current AMA policy H-470.954 supports player education, but is unspecific as to the nature of this education and fails to address the need to change student athlete perceptions of concussion reporting; and

Whereas, There is no current AMA-MSS policy regarding concussion education for athletes; therefore be it

RESOLVED, That our AMA-MSS support adoption of mandated in-person pre-participation concussion education in high school athletic programs aimed at informing student athletes of the risks and signs of concussions and eliminating negative perceptions about the consequences of reporting a head injury.

Fiscal Notes: Minimal, 4

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

**Reduction of Sports-Related Injury and Concussion H-470.954**

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.

2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.

4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE). (CSAPH Rep. 3, A-15) (Appended: Res. 905, I-16)
Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959
1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.

2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.

3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; and (c) promote educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers. (Res. 910, I-10) (Reaffirmed: BOT Rep. 9, A-14) (Modified: CSAPH Rep. 3, A-15)

Injuries in Cheerleading H-470.956
Our AMA: (1) supports the designation of cheerleading as a sport; and (2) recognizes the potential dangers of cheerleading, including the potential for concussion and catastrophic injury, and supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as ‘sports’ by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts. (BOT Rep. 9, A-14) (Reaffirmed: CSAPH Rep. 3, A-15)

Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention 470.007MSS
AMA-MSS will ask the AMA to (1) support collegiate and professional athletic organizations adopting evidence-based guidelines for the evaluation and management of concussions; and (2) encourage further research into the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (MSS Res 20, A-13) (AMA Res 905, I-13 Adopted [H-470.957])

Return to Play After Suspected Concussion 10.010MSS
AMA-MSS will ask the AMA to support the prohibition of athletes under age 18, who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, from returning to play or practice without a licensed health care provider’s written approval. (MSS Res 24, A-10) (AMA Amended Res 910, I-10 Adopted [H-470.959]) (Reaffirmed, MSS GC Rep D, I-15)
Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football 470.008MSS
AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long-term consequences of traumatic brain injuries and concussions in the sport of football at all levels. (MSS Res 46, A-15)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 66
(I-17)

Introduced by: Aaron Sherwood, Talal Alsheqaih, Lara Fahmy, Tabitha Moses, Lauren Newhouse, Aria Basiri, Anthony Eid, Taymaz Joneydian, Wayne State University; Monieka Fortner; University of Kentucky; John-Roger Shepherd; Mayo Clinic; Oscar Reyes, Kori Porosnicu Rodriguez; Johns Hopkins University; Lauren Edgar; Wake Forest School of Medicine; Region 4

Subject: Advocating for Patients' Best Interests in End Stage Renal Disease

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, A landmark longitudinal study published in the NEJM found that the long-term mortality among transplant recipients was 48 to 82 percent lower than patients on dialysis who were waiting for transplantation; and

Whereas, Studies have shown that patients who have successfully received kidney transplants enjoy a better quality and quantity of life than dialysis patients; and

Whereas, The survival benefit of kidney transplantation as compared to dialysis continues to persist even among patients with various comorbid conditions, different forms of health care delivery, and various levels of donor kidney quality; and

Whereas, Despite significant survival advantage of kidney transplant, nearly one third of end stage renal disease patients are not educated about kidney transplantation as a treatment option, even though patients presented with the option have a greater chance of being placed on a transplant list; and

Whereas, Studies have shown that patients who are treated at for-profit facilities have a 26 percent lower rate of placement on transplant lists and 20 percent higher mortality rates; and

Whereas, Dialysis facility philosophies greatly impact whether patients choose to go on the transplant waitlist, and therefore it is necessary for all facilities to present the option in a positive way; and

Whereas, Lower levels of staffing at for-profit dialysis centers could result in the failure to properly educate patients on transplantation services or have them properly assessed for transplantation; and

Whereas, For-profit dialysis centers are more commonly unaffiliated with transplant centers, resulting in a failure to have properly trained staff dedicated to transplant service education; and
Whereas, A recent ruling by the Department of Justice in a whistleblower case against Davita has shown that the privatized dialysis industry has unethically manipulated physicians’ treatment plans through ‘hidden kickbacks’ to physicians; and

Whereas, Hospitalization rates were significantly higher for patients receiving dialysis from for-profit facilities compared to non-profit dialysis facilities; Therefore be it,

RESOLVED, Our AMA recognize kidney transplant as superior to dialysis in patients with end stage renal disease who are eligible for kidney transplants; and be it further,

RESOLVED, Our AMA recognize medical consequences of presenting dialysis as a medically equal alternative to transplant in patients with end stage renal disease; and be it further

RESOLVED, Our AMA advocate for laws requiring privately owned dialysis clinics to present evidence based scientific claims to their patients on dialysis and kidney transplantation regardless of economic interest.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


10. Rabbat CG, Thorpe KE, Russell JD, Churchill DN: Comparison of mortality risk for
dialysis patients and cadaveric first renal transplant recipients in Ontario, Canada. J Am
11. Schold JD, Buccini LD, Goldfarb DA, Flechner SM, Poggio ED, Sehgal AR. Association
between kidney transplant center performance and the survival benefit of transplantation
10.2215/CJN.02380314.
WM, Lea J, Howard D, Gander J, Arriola KJ. iChoose Kidney: A Clinical Decision Aid for
Kidney Transplantation Versus Dialysis Treatment. Transplantation. 2016 March. 100(1)
630–639.
Transplantation in End Stage Renal Disease. World Journal Of Nephrology And Urology.
2014; 3(2), 67-71.
Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation. N
15. Kucirka LM, Grams ME, Balhara KS, Jaar BG, Segev DL. Disparities in provision of
transplant information affect access to kidney transplantation. Am J Transplant. 2012;
17. DaVita whistleblower case alleging kickbacks to doctors settles for $400 million
https://www.phillipsandcohen.com/whistleblower-behind-davitas-record-400-million-
September 6, 2017.
18. Dalrymple LS, Johansen KL, Romano PS, Chertow GM, Mu Y, Ishida JH, Grimes B,
Kaysen GA, Nguyen DV. Comparison of Hospitalization Rates Among For-Profit and
10.2215/CJN.04200413.

RELEVANT AMA AND AMA-MSS POLICY:
Resolved: 67
(I-17)

Introduced by: Nicole Fischer, Pooja Yesantharao, Sakibul Huq, Neha Anand Johns Hopkins School of Medicine; Adam Roussas, the University of Arizona College of Medicine - Tucson; Sumana Kondle, Meharry Medical College

Subject: Food advertising targeted to black and Latino youth contributes to health disparities

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Black and Latino youth exhibit disproportionately higher rates of overweight and obesity compared to their white counterparts; and

Whereas, Black and Latino youth face higher risks for the severe, lifelong health consequences of poor diet and obesity, including cardiovascular disease, asthma, diabetes, and cancer; and

Whereas, It has been shown that blacks and Latinos consume fast food and sugary drinks more often than non-Hispanic white youth; and

Whereas, Exposure to food advertising increases children's and teen's consumption of highly advertised fast food and sugary beverages, increases snacking, and increases total calories consumed; and

Whereas, The Institute of Medicine found that food marketing to children results in increased preferences for nutrition poor foods and increased requests to parents for similarly unhealthy foods; and

Whereas, Children are unable to recognize the persuasive intent of advertising and are therefore unable to modify their interpretations of advertising messages; and

Whereas, Reports have shown that black and Latino youth experience double the amount unhealthy food marketing compared with white non-Hispanic youth; and

Whereas, Companies market nutrition products to poor black and Latino youth at a rate that is disproportionately high as compared with White non-Hispanic youth; and

Whereas, Current AMA policy D-440.978 states that “Our AMA … (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.”; and

Whereas, Current AMA policy H-60.972 states that “It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children.”; therefore be it
RESOLVED, That our American Medical Association establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward black and Latino youth; and
be it further

RESOLVED, That our American Medical Association amend H-60.972 by addition and deletion to read as follows:

(1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children.; and

(2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward minority children, particularly black and Latino children; and be it further

RESOLVED, That our AMA will work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward black and Latino youth.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:
Please note: All formatting of citations must follow the AMA Manual of Style. Examples below.


RELEVANT AMA AND AMA-MSS POLICY:

Banning Food Commercials Aimed at Children H-60.97

It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children. Sub. Res. 220, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmation A-07 Reaffirmation A-12

Culturally Responsive Dietary and Nutritional Guidelines D-440.978

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

Television Commercials Aimed at Children H-485.998

Alcohol and Youth D-170.998

Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. Res. 415, I-01 Reaffirmation A-08

Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973

1. Our AMA will advocate for a ban on the marketing of products such as alcopops, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age.
2. Our AMA supports state and federal regulations that would reclassify Alcopops as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations. Res. 435, A-07 BOT Action in response to referred for decision Res. 411, A-08 Reaffirmed in lieu of Res. 902, I-09
Whereas, The President’s Emergency Plan For Aids Relief (PEPFAR) was started by President George W. Bush in 2003, when only 50,000 people out of approximately 20 million people in sub-Saharan Africa living with AIDS had access to antiretroviral HIV/AIDS medication;¹,⁹ and

Whereas, The goals of the PEPFAR Program include the three pillars of Prevention, Treatment, and Care, all recognized and supported by the existing AMA policies listed below; and

Whereas, As of January 2017, 11.5 million people have access to antiretroviral therapy due to PEPFAR’s funding of antiretroviral therapy as well as prevention efforts;²,³ and

Whereas, PEPFAR’s Population-based HIV Impact Assessments have shown that the epidemic is being controlled for infants and older adults in Zambia, Malawi, and Zimbabwe, with these three countries approaching the 90/90/90 UNAIDS treatment targets;²,⁶ and

Whereas, As of January 2017, 11.5 million people have access to antiretroviral therapy due to PEPFAR’s funding of antiretroviral therapy as well as prevention efforts;²,³ and

Whereas, PEPFAR’s Population-based HIV Impact Assessments have shown that the epidemic is being controlled for infants and older adults in Zambia, Malawi, and Zimbabwe, with these three countries approaching the 90/90/90 UNAIDS treatment targets;²,⁶ and

Whereas, As of 2016, nearly 6.2 million orphans and vulnerable children have received critical care and support aimed at mitigating the emotional, physical, and economic impact of HIV/AIDS on children;¹ and

Whereas, President Donald Trump’s proposed budget for 2018 would lower annual contributions to PEPFAR by 17 percent, from $4.6 billion in the current budget to $3.8 billion. A trend in disinvestment towards the global HIV/AIDS response is due to a number of factors, including delays in bilateral disbursements by the US, donor currency depreciation, and constraints on global aid budgets since the 2008 economic crisis;³,⁶,⁸ and

Whereas, In the first 15 focus resource-limited countries that PEPFAR was focused on until 2008, 20.1 million people are still living with HIV according to UNAIDS data, and about 37 million people worldwide are still infected with HIV;¹,¹⁰ and

Whereas, Prominent figures and organizations leading HIV/AIDS prevention, such as the Bill and Melinda Gates Foundation, agree that cuts would have long-term negative impact on the
family planning and sexual education that is a core component of PEPFAR, leading to more
unintended pregnancies and maternal deaths; and

Whereas, A recent Kaiser Family Foundation report found that overall donor funding for HIV fell
by $500 million in the last year alone (2016 report), bringing totals down to the lowest they have
been since 2010; and

Whereas, An amfAR calculation suggests that proposed cuts to AIDS programs alone could
orphan more than 300,000 children and result in one million deaths; and

Whereas, Our AMA recognizes HIV / AIDS as a global health priority that requires funding on
both a national and international level (H-20.922, H-20.903). Our AMA supports funding for
prevention in the fight against the global AIDS epidemic, including projects such as family life
education to foreign aid programs and guaranteeing pledges against prostitution (H-20.898, H-
20.990); therefore, be it

RESOLVED, That our AMA advocate for the maintenance of President’s Emergency Plan For
Aids Relief funding for the future.

Fiscal Note: Significant, 12

Date Received:

References:

1. The United States President's Emergency Plan for AIDS Relief. PEPFAR: Working
Toward an AIDS-Free Generation. N.d.
2. AIDSinfo | UNAIDS. AIDSinfo | UNAIDS. N.d.
6. Harris, Gardiner. Cuts to AIDS Treatment Programs Could Cost a Million Lives. The New
York Times. May 23, 2017

RELEVANT AMA AND AMA-MSS POLICY:
HIV / AIDS as a Global Public Health Priority H-20.922
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

Global HIV / AIDS Prevention H-20.898
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution.

Global HIV / AIDS Prevention H-20.990
Our AMA extends its support of comprehensive family-life education to foreign aid programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases.

Financing Care for HIV / AIDS Patients H-20.907
(1) Believes that current private insurance and existing public programs, coupled with a significant expansion of state risk pools, provide the best approach to assuring adequate access to health expense coverage for HIV-infected persons and persons with AIDS. However, as the disease patterns and costs become more defined, it may be necessary to reevaluate this conclusion. Continued study of this issue is imperative;
(2) Supports the development of a clinical staging system based on severity of HIV disease as a replacement for the AIDS diagnosis as a basis for determining health, disability, and other benefits;

(3) Supports increased funding for reimbursement and other incentives by public and private payers to encourage (a) expanded availability for therapies and interventions widely accepted by physicians as medically appropriate for the prevention and control of HIV disease and (b) for alternatives to in-patient care of persons with HIV disease, including intermediate care facilities, skilled nursing facilities, home care, residential hospice, home hospice, and other support systems;

(4) Supports government funding of all medical services that are deemed appropriate by both the patient and physician for pregnant seropositive women lacking other sources of funding;

(5) Supports broad improvements in and expansion of the Medicaid program as a means of providing increased coverage and financial protection for low-income AIDS patients;

(6) Supports, and favors considering introduction of, legislation to modify the Medicaid program to provide for a yearly dollar increase in the federal share of payments made by states for care of all patients in proportion to the amount of increase in costs incurred by each state program for care of HIV-positive individuals and patients with AIDS over the preceding year;

(7) Encourages the appropriate state medical societies to seek establishment in their jurisdictions of programs to pay the private insurance premiums from state and federal funds for needy persons with HIV and AIDS; and strongly supports full appropriation of the amounts authorized under the Ryan White CARE Act of 2000;

(8) Supports consideration of an award recognition program for physicians who donate a portion of their professional time to testing and counseling HIV-infected patients who could not otherwise afford these services.

HIV / AIDS and Substance Abuse H-20.903
Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future healthcare needs of both mothers and newborns and (b) adolescent substance abusers,
especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection.

**HIV / AIDS Education and Training H-20.904**

(1) Information on the HIV Epidemic

Our AMA:

a) Vigorously supports the need for adequate government funding for research, both basic and clinical, in relation to HIV/AIDS epidemic. Research on HIV should be prioritized, funded, and implemented in an expeditious manner consistent with appropriate scientific rigor, and the results of research should form the basis for future programs of prevention and treatment;

b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under his/her jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined;

c) Supports ongoing efforts of the Centers for Disease Control and Prevention to periodically monitor the incidence and prevalence of HIV infection in the U.S. population as a whole, as well as in groups of special interest such as adolescents and minorities;

d) Encourages federal and state agencies, in cooperation with medical societies and other interested organizations, to study and report means to increase access to quality care for women and children who are HIV-infected;

e) Encourages further research to assess the risk of HIV transmission in specific surgical techniques and how any such risk may be decreased;

f) Supports exploring ways to increase public awareness of the benefits of animal studies in HIV/AIDS research.

(2) Lookback Studies

Our AMA encourages the cooperation of the medical community and patients in scientifically sound look-back studies designed to further define the risk of HIV transmission from an infected physician to a patient and to determine if there is any scientific basis for the development of a list of exposure-prone procedures. A panel of experts should be assembled to translate available look-back information into a meaningful statement on the estimated true risk of transmission and the need, if any, for additional studies.

(3) Community Research Initiatives

Our AMA supports the objectives of community-based research to reduce HIV disease and encourages periodic review of progress toward these objectives.
Resolution: 69
(I-17)

Introduced by: Corinne Carland, Hannah Martin; Tufts University School of Medicine

Subject: Researching Drug Facilitated Sexual Assault Testing

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, It is estimated that 10–12% of sexual assault victims in emergency rooms are suspected to be drug facilitated sexual assault (commonly known as date rape) victims; and

Whereas, In a national college survey, 5.3% of undergraduate women report having been given drugs without their knowledge or consent and 0.6% of all surveyed women have been sexually assaulted while under the influence of a drug given without their knowledge or consent; and

Whereas, Of the 31 women in this national survey who reported drug-facilitated sexual assault, only 3 had a blood or urine sample taken to test for drugs; and

Whereas, Established accurate methods exist for testing the biological presence of common date rape drugs; and

Whereas, Federal law provides penalties up to 20 years of imprisonment when rape involves giving a victim a drug without the victim’s knowledge, rendering a charge very serious; and

RESOLVED, That our AMA study the feasibility and implications of offering drug testing at point of care for date rape drugs, including rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault.

Fiscal Note: Minimal, 5

Date Received:

References:

whole blood using ultra-performance liquid chromatography time-of-flight mass spectrometry (UPLC–TOF-MS)—Toxicological findings in cases of alleged sexual assault. *Forensic science international*, 222(1), 154-161.


**RELEVANT AMA POLICY:**

**Rape Victim Services H-80.998**
The AMA supports the function and efficacy of rape victim services, encourages rape crisis centers to continue working with local police to help rape victims, and encourages physicians to support the option of having a rape victim counselor present while the victim is receiving medical care.

**Rape Victims H-80.999**
Our AMA supports the preparation and dissemination of information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims.

**Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohypnol H-515.968**
The AMA re-emphasizes to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. The AMA supports public education and public health initiatives regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with ethanol ingestion.

**Addressing Sexual Assault on College Campuses H-515.956**
Our AMA supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.

**RELEVANT AMA-MSS POLICY:**

**295.067MSS Medical Education about Rape Crises**
AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of rape victims, and available rape support groups into their clinical preparation curriculum. (AMA Amended Res 301, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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

515.009MSS Addressing Sexual Assault on College Campuses
AMA-MSS will ask our AMA support universities’ implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting. (MSS Res 7, I-15) (AMA Res 402, A-16 Adopted [H-515.956])
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 70
(I-17)

Introduced by: Aimin Mitwally, Neil Jain, Shivani Patel, Jessica Snyder, Punam Patel, Sulman Mahmood, Rowan University School of Osteopathic Medicine; Adam Roussas, The University of Arizona College of Medicine

Subject: Reintroduction of Mitochondrial Donation in the United States

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Mitochondrial diseases are estimated to affect approximately 1 in 5000 individuals;¹ and
Whereas, There are no existing cures for mitochondrial diseases, and therapy serves only “to alleviate symptoms [and] to slow down the progress of the disease” with varying success;² and
Whereas, The in vitro technique known as mitochondrial donation was introduced as early as 1995 as a means of inhibiting the incidence of inherited mitochondrial diseases;³ and
Whereas, Mitochondrial donation is a technique that involves the replacement of a prospective mother’s oocyte cytoplasm, containing defective mitochondria, with healthy donor oocyte cytoplasm;⁴ and
Whereas, As of 2002, the FDA’s Biological Response Modifiers Advisory Committee (BRMAC) estimated that over two dozen births had occurred in the US using this technique;⁵ and
Whereas, While data on the wellbeing and long-term health of these individuals is not available, research on monkeys conceived via mitochondrial donation suggests that the technique produces viable, healthy offspring;⁶ and
Whereas, BRMAC recommends that “any future work in mitochondrial donation procedures must be cleared by the FDA under Investigational New Drug exemptions” on the grounds that these births represented the first cases of “human germline genetic modification”;⁷ and
Whereas, In 2016, an expert committee from the Institute of Medicine released a statement that claimed the techniques in question only represent a modification of the germline when used to produce female offspring. As such, it rejected a wholesale prohibition of this research, and advised that the technique be limited to male embryos for the time being, such that the modifications would not be carried on to subsequent generations;⁸ and
Whereas, In recent years, the UK’s Human Fertilisation and Embryology Authority determined that the benefits outweigh the risks associated with mitochondrial donation, and the technique was subsequently legalized, making it available to the thousands of couples who could potentially benefit from it;⁹ therefore be it
RESOLVED, That our AMA promotes research to determine the efficacy of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases to at-risk males.
Fiscal Note: Moderate, 8
Date Received:

References:

RELEVANT AMA AND AMA-MSS POLICY:

OPINIONS ON RESEARCH & INNOVATION 7.3.6 Research in Gene Therapy & Genetic Engineering
Gene therapy involves the replacement or modification of a genetic variant to restore or enhance cellular function or the improve response to nongenetic therapies. Genetic engineering involves the use of recombinant DNA techniques to introduce new characteristics or traits. In medicine, the goal of gene therapy and genetic engineering is to alleviate human suffering and disease. As with all therapies, this goal should be pursued only within the ethical traditions of the profession, which gives primacy to the welfare of the patient.

In general, genetic manipulation should be reserved for therapeutic purposes. Efforts to enhance “desirable” characteristics or to “improve” complex human traits are contrary to the ethical tradition of medicine. Because of the potential for abuse, genetic manipulation of nondisease traits or the eugenic development of offspring may never be justifiable.

Moreover, genetic manipulation can carry risks to both the individuals into whom modified genetic material is introduced and to future generations. Somatic cell gene therapy targets nongerm cells and thus does not carry risk to future generations. Germ-line therapy, in which a genetic modification is introduced into the genome of human gametes or their precursors, is intended to result in the expression of the modified gene in the recipient’s offspring and subsequent generations. Germ-line therapy thus may be associated with
increased risk and the possibility of unpredictable and irreversible results that adversely affect the welfare of subsequent generations.

Thus in addition to fundamental ethical requirements for the appropriate conduct of research with human participants, research in gene therapy or genetic engineering must put in place additional safeguards to vigorously protect the safety and well-being of participants and future generations.

Physicians should not engage in research involving gene therapy or genetic engineering with human participants unless the following conditions are met:

(a) Experience with animal studies is sufficient to assure that the experimental intervention will be safe and effective and its results predictable.

(b) No other suitable, effective therapies are available.

(c) Gene therapy is restricted to somatic cell interventions, in light of the far-reaching implications of germ-line interventions.

(d) Evaluation of the effectiveness of the intervention includes determination of the natural history of the disease or condition under study and follow-up examination of the participants’ descendants.

(e) The research minimizes risks to participants, including those from any viral vectors used.

(f) Special attention is paid to the informed consent process to ensure that the prospective participant (or legally authorized representative) is fully informed about the distinctive risks of the research, including use of viral vectors to deliver the modified genetic material, possible implications for the participant’s descendants, and the need for follow-up assessments.

Physicians should be aware that gene therapy or genetic engineering interventions may require additional scientific and ethical review, and regulatory oversight, before they are introduced into clinical practice.

AMA Principles of Medical Ethics: I,V,VII
Whereas, EHRs are an extremely fragmented market with at least 160 systems in use in family practice alone;¹ and

Whereas, only 25% of family practice (FP) EHR users agree or strongly agree that their EHR vendor provides excellent support;¹ and

Whereas, only 28% of FP EHR users are satisfied with their current EHR;¹ and

Whereas, the most common reason for changing EHRs was to add needed functionality;² and

Whereas, changing EHRs resulted in a minimum 50% FP providers to encounter major to moderate challenges in time investment, productivity loss, learning difficulties, transition costs, data loss, and new EHR difficulties;² and

Whereas, no more than 32% of physicians in large practices are happy with their new EHR;² and

Whereas, the cost of purchasing and installing an EHR ranges from $15,000 to $70,000 per provider;³ and

Whereas, there is sufficient evidence to suggest that many existing EHRs lack functionality and support from vendors;¹,² and

Whereas, there is sufficient evidence to suggest that transitioning from any EHR to another may be a difficult endeavor;²,³ and

Whereas, emergent EHR technology, in the form of application markets, data standards, and Application Programming Interfaces (APIs), both standard and proprietary, have emerged or matured from vendors and organizations;⁴ and
Whereas, application programming interfaces (APIs) are toolboxes that third party vendors utilize to have their applications communicate with other software (e.g., EHRs); and

Whereas, in the absence of a standard API, moving an application from one API to a different API (e.g., one EHR to another), inherently requires vendor reprogramming for compatibility, and subsequently weakens interoperability and availability of applications across EHRs; and

Whereas, various industries, such as manufacturing, oil and gas, mining, and transportation, have successfully utilized open, interoperable standards to develop ecosystems of interconnected technologies to advance their goals; and

Whereas, since success has been achieved in other industries using open standards, it is suggested that the EHR market also stands to benefit from these as well; and

Whereas, these recent technologies and standards may impact quality and cost of care, patient experience, and innovation; and

Whereas, open application markets within EHRs increases the potential for additional functions and flexibility within EHRs by introducing vendor competition within an EHR platform; and

Whereas, a greater reliance on third party vendors providing software using APIs in application markets will promote interoperability; and

Whereas, EHR applications are being constructed using proprietary APIs as opposed to a standard API, and are both cost and resource intensive; and

Whereas, only recently, two existing EHRs have begun to offer application markets based on the same standard API (FHIR); and

Whereas, patient and health providers stand to benefit from the adoption of application marketplaces with standard APIs; therefore, be it

RESOLVED, that our AMA research and form recommendations on supporting the adoption of open application markets within EHRs and standard Application Programming Interfaces (APIs); and be it further

RESOLVED, that our AMA research best practices for providers regarding these emergent Electronic Health Records technologies to be dissemination to health professions to inform, moderate disruption, improve EHR satisfaction, and improve care.
References:
3. How much is this going to cost me? HealthIT.gov, Department of Health and Human Services HealthIT, November 12, 2014. Available at: https://www.healthit.gov/providers-professionals/faqs/how-much-going-cost-me

RELEVANT AMA AND AMA-MSS POLICY:

**Technology and the Practice of Medicine G-615.035**
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.

**National Health Information Technology D-478.995**
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

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

EHR Interoperability D-478.972

Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.
Guidelines for Mobile Medical Applications and Devices D-480.972
1. Our AMA will monitor market developments in mobile health (mHealth), including the
development and uptake of mHealth apps, in order to identify developing consensus that
provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to
promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to
facilitate patient communication, advice, and clinical decision support, as well as resources that
can assist physicians in becoming familiar with mHealth apps that are clinically useful and
evidence-based.
4. Our AMA will develop and publically disseminate a list of best practices guiding the
development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care,
particularly to address challenges of reducing work burden while maintaining clinical autonomy
for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation
Council for Graduate Medical Education to develop germane policies, especially with
consideration of potential financial burden and personal privacy of trainees, to ensure more
uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on
proper hygiene and professional guidelines for using personal mobile devices in clinical
environments.

Physician Choice of Practice H-385.926
Our AMA: (1) encourages the growth and development of the physician/patient contract; (2)
supports the freedom of physicians to choose their method of earning a living (fee-for-service,
salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual
fee that is fair, irrespective of insurance/coverage arrangements between the patient and the
insurers. (This right may be limited by contractual agreement.) An accompanying responsibility
of the physician is to provide to the patient adequate fee information prior to the provision of the
service. In circumstances where it is not feasible to provide fee information ahead of time,
fairness in application of market-based principles demands such fees be subject, upon
complaint, to expedited professional review as to appropriateness; and (4) encourages
physicians when setting their fees to take into consideration the out-of-pocket expenses paid by
patients under a system of individually selected and owned health insurance.
Whereas, Tobacco use in the United States accounts for an estimated 480,000 premature deaths per year and more than $289 billion in healthcare expenditures and productivity losses;¹ and

Whereas, Tobacco dependence treatment programs have been shown to effectively lead to cessation of tobacco use;² and

Whereas, Many adult smokers want to quit smoking— as of 2011, 68.9% of adult cigarette smokers wanted to stop smoking, and 42.7% had made a quit attempt in the past year;³ and

Whereas, While smokers attempt to stop on their own with no assistance, the abstinence rate for unaided cessation is typically less than 5%;¹ and

Whereas, Tobacco cessation programs have a receptive target audience for increased utilization; for instance, a 2012 paper found 44.5% of daily smokers showed interested in behavioral interventions and 68.2% showed interest in pharmacotherapy as methods of smoking cessation;⁴ and

Whereas, Tobacco smoking prevention and cessation programs save lives, as a smoker can add 10 years to his or her life on average by quitting at age 30;⁵ and

Whereas, Tobacco smoking prevention and cessation programs save the government billions of dollars annually; recent studies have shown a large return on investment with regards to states’ smoking cessation programs, ranging from five-fold savings to fifty-fold savings on reduced hospitalization costs relative to the cost of the smoking cessation program;⁶,⁷ and

Whereas, Most states’ smoking prevention and cessation programs are severely underfunded by CDC standards,⁸ which recommend anywhere from $8-$348 million be allocated toward tobacco cessation programs and other components of comprehensive tobacco control depending on the state;⁹ and
Whereas, The American Lung Society gave a grade of “F” to 43 states and the District of
Columbia for funding cessation programs at less than half the levels called for by the
CDC in its Tenth Annual State of Tobacco Control Report Card;\textsuperscript{10} and

Whereas, Cigarette taxes have been shown to effectively increase smoking cessation,
and even more so deter youth from beginning to smoke, yielding meaningful public
health benefit;\textsuperscript{11} and

Whereas, Federal and state revenues generated by taxing tobacco products have more
than doubled over the last 20 years despite decreased cigarette smoking, presumably to
retain and capitalize on a lucrative revenue stream;\textsuperscript{12} and

Whereas, A number of states rely on tobacco product taxes as significant sources of
revenue, ranging as high as 4.37% of total tax revenue in New Hampshire as of 2011;\textsuperscript{13}
and

Whereas, Over the last few decades, states have collected hundreds of billions of dollars
in cigarette excise taxes and tobacco industry settlement payments but have invested
comparatively little in state tobacco control programs;\textsuperscript{14} and

Whereas, According to the CDC, in fiscal year 2016, states will collect $25.8 billion from
tobacco taxes and legal settlements but will only spend $468 million—less than 2%—on
prevention and cessation programs,\textsuperscript{15} with the remainder often entering a general state
tax fund;\textsuperscript{16} and

Whereas, The American Cancer Society and other organizations have decried New
Jersey generating billions of dollars in revenue from tobacco excise taxes yet spending
barely 0.8% of this money on cessation programs;\textsuperscript{17} and

Whereas, One reason cessation programs are consistently underfunded may be
because few states have a statutory requirement that a portion of tobacco settlement
fund or tax revenues be dedicated to tobacco control and prevention;\textsuperscript{18} and

Whereas, It is unethical for states and federal government to generate large revenue
streams by targeting and taxing nicotine-addicted individuals without sufficiently funding
programs to help these individuals cease their tobacco dependence, especially as the
public health justification of the tobacco “sin tax” is to curb tobacco use;\textsuperscript{19} and

Whereas, The AMA has already supported policy opposing the diversion of tobacco
company settlement payments towards government programs unrelated to smoker
health and smoking prevention, and opposes the use of such funds to rectify state
budget shortfalls (D-490.484), but does not address similar recommendations for use of
tobacco excise tax funds; and

Whereas, The AMA has already supported policy requesting that local and state
lawmakers allocate at least the CDC recommended minimum amount of the state’s
Tobacco Settlement Fund award annually to smoking cessation and health care related
programs (D-490.976), but does not address similar allocation of tobacco excise tax
funds; and
Whereas, By its ratification of the World Health Organization’s Framework Convention On Tobacco Control, the U.S. government is obligated under Article 13 to take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to develop model state and federal legislation mandating that a greater portion of state and federal tobacco excise tax revenue be used to fund tobacco cessation programs and smoking-related research in order to meet state-specific recommendations put forth by the Centers for Disease Control, and be it further

RESOLVED, That our AMA will work in concert with state medical societies and other allied groups to support the passage of the aforementioned legislation in all states, and be it further

RESOLVED, That our AMA will work in concert with state medical societies and other allied groups to protect CDC-recommended levels of cessation program funding generated through this legislation for appropriate use and issue statements condemning the use of tobacco excise revenue as a way to remedy state budget crises.

Fiscal Note: Significant, 12

Date Received:

References:


RELEVANT AMA AND AMA-MSS POLICY:

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Pres. Address, A-82; Reaffirmed: CLRDP Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed, BOT Rep. 8, I-06)

Tax Free Tobacco Products H-495.982
Our AMA encourages Native American nations to stop selling tax-free tobacco products because of the profound public health implications of the sale of tax-free tobacco products. (CSA Rep. 3, A-04; Reaffirmed, CSAPH Rep. 1, A-14)

Enhanced Education for Abrupt Cessation of Smoking H-490.906
Our AMA encourages research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals. (Res. 408, A-13)

Tobacco Settlement Fund D-490.976
Our AMA supports state and local medical societies in their efforts to formally request that local and state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state’s Tobacco Settlement Fund award annually to smoking cessation and health care related programs, and encourages society members and the public to demand this of their elected officials. (Res. 431, A-07; Reaffirmation, I-11)

FDA Regulation of Tobacco Products H-495.988
1. Our AMA: (A) reaffirms its position that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (C) reaffirms its position that the Food and Drug
Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (D) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (E) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (F) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (G) strongly opposes legislation which would undermine the FDA’s authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA’s authority to regulate tobacco products. 2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Apple: Res. 234, A-12; Reaffirmation; A-13; Modified: Res. 402, A-13; Apple, Res. 420, A-14; Reaffirmation, A-15.

AMA Opposition to Secularization of Tobacco Settlement Payments D-490.984
Our AMA will work in concert with state medical societies to protect the settlement funds, including issuing statements condemning the use of settlement funds as a way to remedy state budget crises. (BOT Rep. 3, I-03; Reaffirmation, I-11)

Federal Efforts Related to Smoking Cessation H-505.963
Our AMA endorses the use of the federally-funded National Tobacco Quitline network and ongoing media campaigns to help Americans quit using tobacco. (CSA Rep. 3, A-04; Modified: CSAPH Rep. 1, A-14)

Continued Action On States’ Allocation of Tobacco Settlement Monies For Smoking Prevention, Cessation and Health Services D-490.997
Our AMA will: (1) translate that commitment into action through aggressive lobbying activities to encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force, when needed, that includes experts in public health, smoking cessation and tobacco prevention programs to ensure that funds are spent on activities supported by the Centers for Disease Control and Prevention guidelines. (Res. 428, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation, I-11)

Tobacco Litigation Settlements H-495.983
Our AMA: (1) strongly supports the position that all monies paid to the states in the Master Settlement Agreement and other agreements be utilized for research, education, prevention and treatment of nicotine addiction, especially in children and adolescents,
and for treatment of diseases related to nicotine addiction and tobacco use; (2) supports efforts to ensure that a substantial portion of any local, state or national tobacco litigation settlement proceeds be directed towards preventing children from using tobacco in any form, helping current tobacco users quit, and protecting nonsmokers from environmental tobacco smoke, and that any tobacco settlement funds not supplant but augment health program funding; (3) strongly supports efforts to direct tobacco settlement monies that are not directed to other specific tobacco control activities to enhance patient access to medical services; (4) strongly supports legislation codifying the position that all monies paid to the states through the various tobacco settlements remain with the states; and that none be reimbursed to the Federal government on the basis of each individual state’s Federal Medicaid match; and (5) opposes any provision of tort reform legislation that would grant exclusion from liability or special protection to tobacco companies or tobacco products. (CSA Rep. 3, A-04; Reaffirmation, I-11)

Ethyl Alcohol & Nicotine as Addictive Drugs H-30.958
The AMA (1) identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people; (2) urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addition; (3) encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and (4) reaffirms that individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease. (Res. 28, A-91; Reaffirmed by CSA Rep. 14, A-97; Reaffirmed: CSAPH Rep. 3, A-07

Taxation of All Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) H-495.987
1. Our AMA will work for and encourages all levels of the Federation and other interested groups to support efforts, including education and legislation, to increase federal, state, and local excise taxes on all tobacco products and electronic nicotine delivery systems (ENDS), including e-cigarettes, in order to discourage use. 2. An increase in federal, state, and local excise taxes for such products should include provisions to make substantial funds available that would be allocated to health care needs and health education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including nicotine dependence, and to support counter-advertising efforts. 3. Our AMA continues to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of all tobacco products; and advocates that the added tax revenues obtained as a result of reducing or eliminating such advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion and health education. (CSA Rep. 3, A-04; Modified: BOT Rep. 8, A-05; Reaffirmed: BOT Rep. 8, A-08; Modified in lieu of Res. 419, A-15)

Smoke Free America H-490.911
Our AMA makes the passage of legislation for a smoke-free America, that includes all public and workplaces and includes provisions for support of smoking cessation programs, a legislative priority for the AMA until such legislation is passed. (Res. 415, A-06; Reaffirmed: BOT Rep. 8, A-08)
WHEREAS, The presence or absence of legislation requiring seat belt use has long been shown to be the most significant correlate with seat belt usage rates, more than any other factor measured; and

WHEREAS, Seat belt usage laws vary across states with two major types of legislative enforcement being primary and secondary seat belt laws; and

WHEREAS, With primary enforcement, a driver can be pulled over and cited for not wearing a seat belt, while secondary enforcement requires that the driver must first be pulled over for a primary offense, such as speeding; and

WHEREAS, There are currently 16 states without primary seat belt laws; and

WHEREAS, Secondary laws have less of an effect compared to primary laws in increasing seat belt usage; and

WHEREAS, Primary seat belt states benefited from higher seat belt usage rates by approximately 9.1% in 2016; and

WHEREAS, It is estimated that increasing the national average of seat belt usage by 1% can save 136 lives per year; and

WHEREAS, Switching to primary seat belt laws have proven to have both immediate and permanent effects leading to increased usage of seatbelts, as opposed to educational programs promoting seat belt usage alone; and
WHEREAS, There are financial benefits in increasing seat belt usage and switching to primary seat belt laws\(^7,8\); and

WHEREAS, In study conducted from 1979-2006, the National Highway Traffic Safety Administration (NHTSA) estimates that $913 billion dollars in medical and medically related expenses could have been saved had individuals in motor vehicle crashes been wearing seat belts\(^7\); and

WHEREAS, A 2009 estimate predicted that the United States could save over $261 million a year if all 17 states without primary seat belt laws at that time were to upgrade to primary law enforcement\(^8\); and

WHEREAS, AMA Policy H-15.993 “urges all physicians and healthcare professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts...”; and

WHEREAS, Youths have estimated higher seat belt usage improvement rates when primary seat belt laws are implemented than their relatively low risk counterparts\(^9\); and

WHEREAS, Switching to primary seat belt laws increased seat belt usage by teens by 45–80% and lowered fatality rates by 17% in 10-24 year olds\(^9,10\); and

WHEREAS, Minority groups consistently show lower seat belt usage rates and show the biggest improvements with the implementation of primary seat belt laws\(^11,2\); and

WHEREAS, Implementing primary seat belt enforcement protects more lives than just the restrained driver; and

WHEREAS, Death in drivers and front seat passengers is increased five-fold when a backseat passenger is not wearing a seat belt\(^12\); and

WHEREAS, Drivers who use seat belts positively influence other passengers in the car to also wear seat belts\(^13\); and

WHEREAS, Our AMA recognizes the importance of physician involvement in increasing seat belt usage, as demonstrating in AMA Policy H-15.962 and H-15.990; therefore be it

RESOLVED, That our AMA support the implementation of primary seat belt legislation in all states; and be it further

RESOLVED, That our AMA work to draft and advocate for model primary seat belt legislation in states without primary seat belt laws.

Fiscal note: Significant, 12
References:

RELEVANT AMA POLICY:

**Child Passenger Safety H-15.993**
Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in motor vehicles with appropriate restraining systems.

**Mandatory Seat Belt Utilization Laws H-15.982**
Our AMA (1) supports mandatory seat belt utilization laws which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (2) favors informing state medical societies about the status of mandatory seat belt utilization laws which simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (3) urges reconsideration of the administrative regulation of the U.S. Department of Transportation that would release automobile manufacturers from the responsibility of providing passive restraints when mandatory seat belt utilization for two-thirds of the U.S. population is attained; and (4) supports the amendment of state seat belt laws which contain exemptions for emergency medical services personnel, such that these laws would provide exemptions only when personnel are actively involved in patient care.

**Automobile-Related Injuries H-15.990**
Our AMA:
(1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries.
(2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal.
(3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles.
(4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children.
(5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes.
(6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement.
(7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention.
(8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good
practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers’ lines of vision; removal of obstructions; and separation of opposing traffic streams.

(9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions.

(10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior.

(11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers.

(12) Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption.

(13) Will work with interested state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints.

Air Bags and Preventing Crash Injuries H-15.962
Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries;

(2) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and

(3) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 74
(1-17)

Introduced by: Region 1; Omar Mesina, Emily Wong, University of California, San Francisco; Abhinaya Narayanan, University of California, Los Angeles David Geffen School of Medicine; David Patron, University of California, Los Angeles, Charles Drew University

Subject: Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Structural racism is defined as the macro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate, reinforce, and perpetuate inequities among racial and ethnic groups;¹ and

Whereas, Significant differences exist between minority groups and non-minority groups in access to adequate and equitable housing, quality education, employment, safe neighborhoods, health care, and generational wealth;²,³ and

Whereas, These differences in access have significant effects on health, quality of life, and length of life and are perpetuated through socio-cultural forces at play over generations;⁴-⁶ and

Whereas, Ongoing exclusion of and discrimination against people of color throughout their life course, by virtue of their unique history in the United States, along with the legacy of harmful past policies, continues to shape patterns of disease distribution and mortality among these groups in particular;⁷ and

Whereas, A long history of medical experimentation on people of color in the United States, including but not limited to African Americans in the Tuskegee syphilis study, has contributed to distrust of the medical field, particularly among patients of color;⁸-¹⁰ and

Whereas, Many medical trainees report feeling overwhelmed when exposed to the social, cultural, and historical contexts that contribute to causes and effects of differences and differential access to resources between minority groups and non-minority groups;¹¹ and

Whereas, The American Congress of Obstetricians and Gynecologists has acknowledged that an equitable health care system cannot be realized without examining the historical context from which disparities grow, and without examining these disparities through a lens that takes into account race, gender, and class;¹² and

Whereas, Medical providers can and should play a pivotal role in addressing racism, social injustice, and inequality in the educational and health care systems, through research, policy, teaching, and clinical practice;¹³,¹⁴ and
Whereas, Existing AMA policy acknowledges social determinants of health—including physical and social environment, economic stability, education, and access to health care—but fails to recognize the ways in which the legacy of racism and existing structural racism contribute to health disparities;\(^{15,16}\) and

Whereas, Growing evidence suggests that a focus on interpersonal communication and clinician bias regarding race leaves larger questions of systemic bias in healthcare unaddressed;\(^{17,18}\) and

Whereas, The Liaison Committee on Medical Education (LCME) standards for medical school accreditation include curricular requirements for education in cultural competence and healthcare disparities;\(^{19}\) and

Whereas, The AAMC developed the Tool for Assessing Cultural Competence Training (TACCT), a self-administered assessment tool that medical schools can use to evaluate aspects of cultural competence training at their institutions—including bias, discrimination, race, and the history of stereotyping—but this is merely a tool and does not specifically mandate the inclusion of such topics in cultural competency education;\(^{20}\) and

Whereas, Cultural competency courses for physicians-in-training do not adequately address structural racism, which can result in the persistence of stereotyping of people of color that contributes to the diseases and conditions observed in their patients;\(^{21}\) and

Whereas, Over-simplified cultural competency training in medical schools contributes to stereotyping of cultures, giving students a framework for thinking about differences but not providing a toolkit for engaging in anti-racist behaviors;\(^{22,23}\) therefore be it

RESOLVED, That our AMA advocate for cultural competency medical education that highlights the ways in which historical practices within the medical field—including but not limited to medical experimentation—have affected communities of color in the US and their relationships with the medical community; and be it further

RESOLVED, That our AMA support the integration of pre-clinical coursework on structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US and how these impact health, access to care, health care delivery, and the provider-patient relationship; and be it further

RESOLVED, That our AMA advocate for the insertion of specific anti-racism and cultural humility competencies into the LCME’s current list of cultural competencies for medical students, to include training in structural racism and how historical practices of medicine affect access to and quality of health care for patients of color.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


16. 295.181MSS - Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum.


23. Jenks AC. From “lists of traits” to “open-mindedness”: emerging issues in cultural

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

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

**295.181MSS - Providing Greater Emphasis on the Social Determinants of Health in Medical School Curriculum:**

AMA-MSS will ask the AMA to support meaningful integration of issues pertaining to the social determinants of health and health disparities in medical school curricula that emphasize strategies for recognizing and addressing the needs of patients from marginalized populations. (MSS Res 12, A-14) (AMA Res 908, I-14 Adopted as Amended [H-295.874])

**160.033MSS - Expanding Access to Screening Tools for Social Determinants of Health:**

AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. (MSS Res 03, I-16) (AMA Res 711, A-17 Referred)

**440.063MSS - Recognizing Poverty-Level Wages as a Social Determinant of Health:**

AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health. (MSS Res 37, A-17)

**Relevant AMA Policy:**

**D-350.984 - Reducing Discrimination in the Practice of Medicine and Health Care Education**

Our AMA will pursue avenues to collaborate with the American Public Health Association’s National Campaign Against Racism in those areas where AMA’s current activities align with the campaign.

**H-350.974 - Racial and Ethnic Disparities in Health Care**
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association. The AMA emphasizes three approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

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

H-295.897 - Enhancing the Cultural Competence of Physicians
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.

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

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

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

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

6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

H-295.878 - Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients.
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 75
(I-17)

Introduced by: Rebecca DiBiase and Sahana Jayaraman, Johns Hopkins School of Medicine, Aubrey Graham, University of Illinois College of Medicine at Rockford

Subject: Lowering mental health stigma by implementing mental health educational training early in medical school for peers and colleagues

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, All healthcare providers, regardless of specialty, have patients who require mental health services;¹,²,³ and

Whereas, Research shows that healthcare professionals have an aversion to patients with primary or comorbid psychiatric conditions, which causes them to receive sub-standard care via negative or condescending communication styles, over-diagnosis, projected pessimism about prognosis, and tendency toward restrictive interventions;⁴,⁵,⁶ and

Whereas, Early training in medical school plays a pivotal role in shaping students’ perceptions of different types of patients and training in medical school that is both sensitive and appropriate is essential to improve future physicians’ perceptions of and behaviors toward the mental health community;¹,³,⁴,⁷,⁸ and

Whereas, A course implemented in the first year of medical school about experiences with mental health showed a decrease in stigma associated with mental illness and an increased willingness to interact with individuals affected by mental illness;⁹ and

Whereas, The medical student population is more susceptible to both mental health disorders and suicidal ideation when compared to the general public, leading to potential mental health distress and suicide crisis situations within medical students’ peers;¹⁰,¹¹,¹²,¹³ and

Whereas, Current AMA policy H-295.858 recommends screening and prevention efforts for medical students in an attempt to combat mental health stigma and identify at-risk individuals but does not address training for students within their first year to effectively identify or intervene in mental health distress or crisis situations both inside and outside a clinical context for their peers and colleagues;¹⁴ and

Whereas, Current AMA policy H-345.972 supports federal funding for training of law enforcement and community participation in crisis intervention training programs, no such program is currently implemented within the first years of medical school;¹⁵ therefore be it

RESOLVED, That our AMA-MSS encourage medical schools to implement educational training programs for medical students within the first year to help lower mental health stigma toward peers, colleagues, and future patients, and to provide tools to confidently identify and intervene in the event of mental health distress or crisis among their peers and colleagues.
References:

RELEVANT AMA AND AMA-MSS POLICY:
Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; and (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. Res. 923, I-15

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

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
   A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
   B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
   C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
   D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
   A. be available to all medical students on an opt-out basis;
   B. ensure anonymity, confidentiality, and protection from administrative action;
   C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
   D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

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

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.98

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs’ clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.


Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person’s identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. CMS
Medical Student Support Groups H-295.999
(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. (2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. Res. 164, A-79 Reaffirmed: CLRPD Rep. B, I-89 Reaffirmed: CME Rep. 4, I-98 Reaffirmed: CME Rep. 2, A-08

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive. (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs. (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health. (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.

Discrimination Against Patients by Medical Students H-295.865
Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

Increasing Detection of Mental Illness and Encouraging Education D-345.994 (1) Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers. (2) Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Physicians, Psychotherapy and Mental Health Care H-345.996
Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public.

Expansion of Student Health Services 295.137MSS
AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage. (MSS Rep D, I-05, AMA Res 309, A-06, Referred) (CME Rep 6, A-07 Adopted [H-295.956]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS**

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

**Stigmatization of Mental Health Disorders within the Medical Profession 345.004MSS**

AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization. (MSS Res 37, A-11) (Modified: MSS GC Report A, I-16)

**Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS**

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15).
Resolution: 76
(I-17)

Introduced by: Sierra Tackett, Medical College of Wisconsin; Michael Muradian, Medical College of Wisconsin; Nathan Carpenter, Medical College of Wisconsin; Michael Rigby, University of Wisconsin School of Medicine and Public Health; and Taylor Boland, University of Wisconsin School of Medicine and Public Health

Subject: Opioid Treatment Programs Reporting to Prescription Monitoring Programs.

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

____________________________________________________________________

Whereas, complete knowledge of a patient’s opioid medication history is necessary for physicians to provide the best care, allows for open, honest dialogue and shared decision making; and

Whereas, the prescription monitoring programs can provide information to physicians that may not be available within their electronic health records system about patients’ current and past opioid use, tolerance, potential drug interactions, and other risk factors the patient may have; and

Whereas, usage of the prescription monitoring programs may prevent dangerous prescribing patterns and limit polypharmacy;\(^1\) and

Whereas, incomplete or inaccurate information limits providers’ ability to utilize prescription monitoring programs;\(^2\) and

Whereas, opioid treatment programs do not currently report prescribing and dispensing activity to state prescription monitoring programs;\(^3\) and

Whereas, patients on opioid replacement therapy are at high risk for overdose and being prescribed interfering medications such as benzodiazepines or other opioids;\(^4\) and

Whereas, opioid treatment information in the prescription monitoring programs, which is obtained from opioid treatment programs, will help prevent other physicians from prescribing opioid or benzodiazepine medications that could interfere with medication assisted treatment in cases that the patient does not disclose their treatment; therefore be it
RESOLVED, That our AMA amend the policy Opioid Treatment and Prescription Drug Monitoring Programs D-95.980 by deletion:

That our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Fiscal Note: Minimal, 5

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

AMA Policy:
Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices: A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical
students. B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms. 2. Our AMA: A. promotes physician training and competence on the proper use of controlled substances; B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients; C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and D. encourages physicians to query a state’s controlled substances databases for information on their patients on controlled substances. 3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities. 4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

**Prescription Drug Monitoring Program Confidentiality H-95.946**

Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

**Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.946**

Our AMA:

(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;

(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;

(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;

(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;

(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;

(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;

(8) will advocate for physicians and other healthcare professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and

(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Universal Prescriber Access to Prescription Drug Monitoring Programs H-95.927
Our AMA supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.

Support for Prescription Drug Monitoring Programs H-95.929
Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide
education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:
A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

AMA-MSS Policy:

120.009MSS Restrictions on Use of Physician Prescribing Data for Commercial Purposes

AMA-MSS (1) supports limiting the use of physician prescribing data from any and all sources for commercial purposes, including its use by pharmaceutical companies; and (2) supports the availability of physician prescribing data to organizations using it for public health research, law enforcement, adverse effects reporting, and all other noncommercial purposes.
Resolution 77
(I-17)

Introduced by: Amy Steinhauer, Juhee Patel, Shikha Patel, Stefanie Suarez, Akanksha Kapoor, Mark Shepard and Jenna Guma; Rowan University School of Osteopathic Medicine

Subject: Incorporation of Sun Protection Educational Program into Elementary School Health Curricula

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Skin cancer is the one of the most common types of cancer in the United States, with rates increasing over the past 30 years;¹ and

Whereas, Research has shown, “one blistering sunburn during childhood or adolescence can nearly double a person’s chance of developing melanoma;”¹¹ and

Whereas, Studies have shown that using sunscreen is one of the ways that can help lower the risk of developing skin cancer by reducing exposure to harmful UV rays;² and

Whereas, Research has shown that implementing sun protection habits early in childhood, greatly reduces skin cancer risk later in life;³ and

Whereas, The CDC provides guidelines for school programs to prevent skin cancer by shaping the development and encouraging implementation of district policy for students,⁴ and

Whereas, Research has shown that school based educational programs are an effective method to increase knowledge and healthy sun behaviors in children;⁵ and

Whereas, There already exists AMA-MSS policy to encourage elementary schools to develop sun-protection policies (60.011MSS); therefore be it

RESOLVED, That our AMA-MSS amend policy 60.011MSS by addition as follows: “AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop evidence-based sun protection policies,” use these policies to design a sun protection educational program, and integrate this program into previously existing health curricula.

Fiscal Note: Significant, 12

References:


RELEVANT AMA AND AMA-MSS POLICY:
60.011MSS Sun Protection Programs in Elementary Schools
AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (MSS Res 16, A-04) (Reaffirmed: MSS Res 16, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (MSS Res 12, I-05) Sun Safety Education in Elementary Public Schools: The MSS formally establishes support for the following HOD policy: D-170.997 Sun Protection Programs in Elementary Schools Our AMA will work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (Res. 403, A-05)
Whereas, More than 60% of children and adolescents across different demographics have reported to being victim or witness to a form of violence;\(^1\) and

Whereas, Childhood exposure to violence has been linked to negative long-term consequences, such as future commitment of violence, symptoms of trauma, feelings of helplessness, and negative school performance;\(^2,3,4,5,6\) and

Whereas, The most likely predictor of a subsequent case of a shooting in street or gang violence is a previous shooting;\(^7\) and

Whereas, As of 2010, the cost of violence in the United States was estimated to be at least $460 billion;\(^8\) and

Whereas, WHO reports have shown that intervention programs based on public health models for early childhood, parenting, and family therapies correlate to a long-term decrease in violent behaviors;\(^5\) and

Whereas, Cities that have implemented effective and evidence-based public health violence prevention models, such as the Cure Violence model, have seen a significant drop in violent acts, most notably showing an 80%-100% reduction in retaliation attacks;\(^9,10\) and

Whereas, The CDC has endorsed a science-based four-step public health approach to violence prevention;\(^11\) and

Whereas, The AMA supports “investment in primary prevention activities related to violence,” as well as in research and services that encourage physicians to get involved in violence prevention (H-515.964); and

Whereas, H.R.2757 Public Health Violence Prevention Act has been introduced to the 115th Congress by Representative Quigley and aims to fund public health violence prevention models through a grant based system;\(^12\) and therefore be it

RESOLVED, That our AMA supports legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence.
References:


RELEVANT AMA POLICY:

Violence Activities H-515.964

Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes; (2) specifically endorses the WHO’s World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and (3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine.
Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement.

Violence and Abuse Prevention in the Health Care Workplace H-515.966
Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.

Family Violence-Adolescents as Victims and Perpetrators H-515.981
The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Health Care Costs of Violence and Abuse Across the Lifespan D-515.984
1. Our AMA urges Congress to commission the Institute of Medicine to study and issue a report on the impact and health care costs of violence and abuse across the lifespan.
2. Our AMA: (a) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse; and (b) will develop and implement a strategy to advocate for increased funding for such research.
3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

Public Health Policy Approach for Preventing Violence in America H-515.971
The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts.
Introduced by: Rajitha Reddy, University of Texas Health San Antonio Long School of Medicine; Rose Ann Huynh, University of Texas Health San Antonio Long School of Medicine Tabitha Moses, Wayne State University School of Medicine

Subject: De-stigmatizing seeking treatment for depression and other mental illnesses by amending state licensure applications

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Compared to the general population, physicians are more likely to experience burnout, depressive symptoms and suicidal attempts;¹ ² and

Whereas, A majority of states contain medical licensure questions that allude to both past and current treatment of mental health and substance abuse in physicians;³ ⁴ and

Whereas, Some of these questions, based on the definition of disability by the American Disabilities Act, can be considered impermissible or likely impermissible secondary to the lack of a specified time limitation of such condition or lacking relation to the ability to perform certain essential functions of a physician;⁴ and

Whereas, In a survey conducted by Gold et al., 44% of 2,015 female physicians responded with "did not want to ever have to report to medical board or hospital" for reasons for not seeking treatment;⁵ and

Whereas, Seeking treatment can improve patient safety by allowing physicians to be working at their optimal state;⁶ and

Whereas, Physicians with impairment are commonly classified as substance abuse cases compared to isolated depression cases, which uncommonly present;⁷ therefore be it

RESOLVED, That AMA support the revision of medical licensure questions, concerning mental health, so that they better encourage and reward the seeking of treatment among physicians with past or current mental health events.; and be it further

RESOLVED, That AMA support state medical board communications to physicians that seeking treatment has less severe consequences than not seeking treatment for an illness; and be it further

RESOLVED, That AMA encourage state licensing agencies to treat a physician diagnosed with depression only as a separate group in the application due to the nature of the illness, rare occurrence of impairment, and need to take a step forward in de-stigmatizing depression via state licensing boards.

Fiscal Note: Significant, 10
Date Received: 9/20/17

References:

7. Texas Medical Board. Medical Board decisions FY 1997 to FY 2007. Enforcement statistics

RELEVANT AMA AND AMA-MSS POLICY:

**Physician Impairment H-275.940**
The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician.

**Physician Impairment H-95.955**
(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

**Impairment and Disability Evaluations H-90.977**
It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations.

**Revising "Guides to the Evaluation of Permanent Impairment" H-365.987**
It is the policy of the AMA: (1) to pursue the comprehensive revision and updating of the Guides to the Evaluation of Permanent Impairment with input from physicians in all appropriate
specialty groups; and (2) to consider developing appropriate methods to facilitate the use of the Guides, including expansion of introductory instructions.

**Impairment Prevention and Treatment in the Training Years H-295.863**
Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.

**Medical Licensure H-275.978**
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of re-registering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of re-registration except when there is reason to believe that a physician's knowledge of medicine is deficient;

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

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

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.
Introduced by: Taymaz Jonyedian, Alex Poznanski, Fereshteh Azad, Tabitha Moses, Rex Hubbard, Aria Basiri; Wayne state School of Medicine.

Subject: Equalizing reimbursement for Psychotherapy and Drug-therapy

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Third-party reimbursement for one 45- to 50-minute outpatient psychotherapy session is 40.9% less than reimbursement for three 15-minute medication management visits;¹ and

Whereas, The increasing cost of medical education and heavy debt, drive new psychiatrists' need to earn more now than in the past, discouraging them from administering psychotherapy;² and

Whereas, A physician's choice of treatment should not depend on the compensation but should be selected based on treatment efficacy backed by evidence based practice;³ and

Whereas, Patients show a three-fold preference for psychotherapy relative to medication for treatment of psychiatric disorders, and the patients who receive their treatment of choice have better outcomes than those whose treatment is incongruous with their preferences;⁵,⁶ and

Whereas, Patients who pay out of pocket are most likely to receive psychotherapy, followed by patients with private insurance, patients with public insurance are least likely to receive psychotherapy;¹ and

Whereas, Studies found that psychotherapy is generally viewed by patients as the most acceptable treatment for depression, and concerns for medication use included potential side effects;⁷ and

Whereas, The adverse side effects of psychotherapy are often related to actions of a poorly trained or less experienced therapist;⁸ and

Whereas, For certain conditions (e.g. Cluster A personality disorders and Major Depression) evidence suggests talk therapy to be at least as efficacious as pharmacotherapy and in some cases it is the only available treatment;⁴,⁵ and

Whereas, Diagnosis of conditions such as BPD require many sessions in the shape of talk therapy,¹⁰,¹¹ and

Whereas, A patient who is never diagnosed, misdiagnosed or not treated effectively may have a lower quality of life,¹⁰,¹¹ and
Whereas, Psychotherapy provided by a licensed psychiatrist offers the patient with more intensity of treatment in terms of mean face-to-face treatment minutes per patient per month; and

Whereas, Psychiatrists can provide more intense treatment regimens to patients with more severe mental, physical and emotional conditions compared to therapy provided by other parties that provide talk therapy; and

Whereas, Overall psychiatry showed the highest percentage of gold standard training in Evidence Based Training (28.1% of EBT) and non-EBT (45.6% of non-EBT) as compared to other parties that provide talk-therapy; and

Whereas, Psychiatrists are the only group of mental health care providers capable of prescribing medicines and providing integrative pharmacotherapy and psychotherapy; therefore, be it

RESOLVED, Our AMA advocate for same compensation for psychotherapy sessions as drug therapy sessions, when the psychotherapy has been supported by clinical evidence to be the only available option or has similar efficacy to drug therapy; and be it further

RESOLVED, Our AMA advocate for the same compensation for psychotherapy in combination with drug-therapy, when the combination’s efficacy is supported by clinical evidence.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


**RELEVANT AMA ANDAMA-MSS POLICY:**

**Reimbursement by Medicare for Psychotherapy Provided by Residents H-330.939**
The AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy.

**Physicians, Psychotherapy and Mental Health Care H-345.996**
Our AMA supports efforts to inform physicians, the public and third-party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public.

**Payment for Physicians' Services H-385.990**
Our AMA:

1. Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.

2. Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.

3. Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.

4. Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.
Whereas, The Genetic Information Nondiscrimination Act (GINA) currently forbids health insurance discrimination based on genetics but does not provide protection for long-term care, life, or disability insurance;\(^1\) and

Whereas, GINA identifies the unethical nature of genetic discrimination;\(^1\) and

Whereas, Limitations of genetic risk data protection remains a poorly understood topic amongst the general population;\(^2,3,4\) and

Whereas, GINA defines an individual's genetic information to include not only the results of their own genetic tests, but also those of family members ,\(^1,5\) and

Whereas, Genetic testing does not require consent of other related parties who may be impacted by the results,\(^5,6\) and

Whereas, Direct to consumer genetic risk testing is dramatically increasing the availability of highly sensitive genetic information;\(^3,4,7\) and

Whereas, Awareness of one's genetic risk allows for earlier detection, treatment, and better patient outcomes,\(^9,10,11\) and

Whereas, Current AMA policy (H-65.969) stands in opposition to genetic discrimination, but no such AMA-MSS policy exists; and

RESOLVED, That our AMA-MSS (1) strongly opposes any discrimination based on genetic information; (2) support robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections and limitations against genetic discrimination currently afforded by federal and state law; and be it further

RESOLVED, That our AMA-MSS formally establish support for 4.1.3 Third-Party Access to Genetic Information and 7.3.7 Safeguards in the Use of DNA Databanks in the AMA Code of Ethics.

Fiscal Note: Minimal, 4
Date Received:

References:
5) Bonython, WE, Arnold, BB. Yours, mine, or ours: cautions about LRT. *J Med Ethics.* 2017; Epub. doi:10.1136/medethics-2016-103778.

RELEVANT AMA AND AMA-MSS POLICY:

Genetic Discrimination and the Genetic Information Nondiscrimination Act H-65.969
Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws.

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
   (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients’ privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients’ informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconseunted access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patient's medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for “business decisions,” including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of
patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Genetic Information and Insurance Coverage H-185.972
AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.
(2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services.
(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.
(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

4.1.3 Third-Party Access to Genetic Information
The rapid pace of development and dissemination of genetic testing has made it possible to generate information about individuals across a wide and growing spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual’s health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information.
Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual. Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to:
(a) Maintain the confidentiality of the patient’s health information, including genetic information.
(b) Release a patient’s genetic information to third parties only with the patient’s informed consent.
(c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient’s request and with their informed consent.

7.3.7 Safeguards in the Use of DNA Databanks:
DNA databanks facilitate population-based research into the genetic components of complex diseases. These databanks derive their power from integrating genetic and clinical data, as well as data on health, lifestyle, and environment about large samples of individuals. However, the use of DNA databanks in genomic research also raises the possibility of harm to individual participants, their families, and even populations. Breach of confidentiality of information contained in DNA databanks may result in discrimination or stigmatization and may carry implications for important personal choices, such as reproductive choices. Human participants who contribute to research involving DNA databanks have a right to be informed about the nature and scope of the research and to make decisions about how their information may be used.

In addition to having adequate training to be able to discuss genomic research and related ethical issues with patients or prospective research participants, physician-researchers who are involved in genomic research using DNA databanks should:

Research involving individuals

(a) Obtain informed consent from participants in genomic research, in keeping with ethics guidance. In addition, physicians should put special emphasis in the consent process on disclosing:

(i) the specific privacy standards to which the study will adhere, including whether the information or biological sample will be encrypted and remain identifiable to the researcher or will be completely de-identified;
(ii) whether participants whose data will be encrypted rather than de-identified can expect to be contacted in the future about findings or be invited to participate in additional research, either related to the current protocol or for other research purposes;
(iii) whether researchers or participants stand to gain financially from research findings, and any conflicts of interest researchers may have in regard to the research, in keeping with ethics guidance;
(iv) when, if ever, archived information or samples will be discarded;
(v) participants’ freedom to refuse use of their biological materials without penalty.

Research involving identifiable communities

(b) When research is to be conducted within a defined subset of the general population, physicians should:

(i) consult with the community in advance to design a study that is sensitive to community concerns and that will minimize harm for the community, as well as for individual participants. Physicians should not carry out a study when there is substantial opposition to the research within the community of interest;
(ii) protect confidentiality by encrypting any demographic or identifying information that is not required for the study’s purpose.

AMA Principles of Medical Ethics: I,IV,V,VII

Clinical Application of Next Generation Genomic Sequencing H-460.905

1. Our AMA recognizes the utility of next-generation sequencing (NGS)-based technologies as tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes.
2. Our AMA encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests.
3. Our AMA will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies.
4. Our AMA will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate.
5. Our AMA will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process.

**Genomic-Based Personalized Medicine H-460.908**
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

**D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing**
(1) recommends that genetic testing be carried out under the personal supervision of a qualified healthcare professional;
(2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information;
(3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test;
(4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information;
(5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

**165.010MSS Development and Support of Prospective Personalized Health Planning:**
AMA-MSS will ask the AMA to: (1) continue to recognize the need for possible adaptation of the United States’ health care system to prospectively prevent the development of disease by
ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models, and measures that will assist in creating a stronger focus on prospective care in the United States’ health care system; and (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing. (MSS Rep F, A-04) (AMA Res 422, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems:
Our AMA-MSS will ask (1) That our AMA support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) , That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results; and (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. (MSS Res 11, A-16).

The MSS formally establishes support for the following HOD policies:
H-460.908 Genomic-Based Personalized Medicine
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

The MSS formally establishes support for the following HOD policies:
D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing
Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified healthcare professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians
to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.
Whereas, approximately 3.6 million Americans miss or delay medical care due to lack of access to non-emergency medical transportation;¹ and

Whereas, delays in care due to transportation barriers worsens patient outcomes;²,³ and

Whereas, digital transportation network companies offer improved cost and user experience;⁴-⁶ and

Whereas, digital transportation network companies have announced efforts to bring new transportation technologies to healthcare;⁷ and

Whereas, our AMA has previously encouraged the development of non-emergency patient transport systems that are affordable to patients (AMA policy H-130.954); and

Whereas, there is a lack of evidence on patient use and safety of these services²⁸; therefore be it

RESOLVED, that our AMA encourage collaboration between industry leaders, insurance companies, and healthcare institutions to evaluate the safety and cost efficacy of increased use of digital transportation networks for non-emergency medical transport; and be it further

RESOLVED, That our AMA support the maintenance of patient safety as the paramount guiding feature of all non-emergent digital transportation network endeavors.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


RELEVANT AMA POLICY:

Non-Emergency Patient Transportation Systems H-130.954
The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.
Whereas, Medical Nutrition Therapy (MNT) is a diet-based therapeutic approach to treating chronic disease that is currently covered under Medicare Part B for diabetes, kidney disease, and kidney transplants;¹ and

Whereas, Overweight and obese patients who utilized medical nutrition therapy lost more weight, on average, and had a higher probability of exercising more than patients who did not partake in the therapy, in a study of Blue Cross and Blue Shield of North Carolina's Member Health Partnership program;² and

Whereas, Within seven months of adopting a plant-based high nutrient density diet that emphasizes greens and other non-starchy vegetables, 62% of diabetic patients achieved a normoglycemic HbA1C;³ and

Whereas, Plant-based diets can alleviate pain associated with neuropathy; in one study, seventeen of twenty-one patients felt complete pain relief in as little as four days, and five of twenty-one patients no longer needed blood sugar medications after one month;⁴ and

Whereas, Plant-based diets have shown reduce serum LDL in healthy volunteers by approximately 30%, similar to 1st generation statin drugs;⁵ and

Whereas, Coronary artery disease (CAD) is reversible with diet, even in advanced stages. In a study in which 11 patients with severe cardiac disease adopted a whole food, plant-based diet, all 11 (100%) patients arrested their disease progression on five year angiogram and 8 (73%) reversed progression;⁶ and

Whereas, Patients with chronic kidney disease who did not undergo MNT were 3.15 times more likely to start dialysis than patients who did receive the therapy; furthermore, patients
experience better outcomes when MNT is given at CKD Stage 3 or 4 rather than waiting until
Stage 5; and

Whereas, MNT has been found to improve eating behaviors and lower triglyceride levels
independent of medication and prior nutrition counseling in patients with refractory severe
hypertriglyceridemia; and

Whereas, MNT decreased HbA1c in prediabetic patients compared to the usual care control
group; and

Whereas, Nutritional intervention is a cost-effective means for reducing the incidence of
pressure ulcers in hospitalized patients; and

Whereas, There exist low-cost models of MNT, including one in a managed care environment
with an incremental cost of approximately $0.03 per member per month; and

Whereas, In patients 60 years and older with either HTN or HLD, an MNT program was a cost-
effective mechanism for increasing Quality-Adjusted Life-Years; therefore be it

RESOLVED, That our AMA support expansion of Medicare Part B criteria for Medical Nutrition
Therapy to include early-onset chronic disease.

Fiscal note: Minimal, 5

Date Received: 5

References:

1) Nutrition therapy services (medical). https://www.medicare.gov/coverage/nutrition-
therapy-services.html
2) Bradley DW, Murphy G, Snetselaar LG, Myers EF, Qualls LG. The Incremental Value of
improved in type 2 diabetes with the high nutrient density (HND) diet. Open Journal of
4) Crane MG, Sample C. Regression of diabetic neuropathy with total vegetarian (vegan)
5) Jenkins DJ, Kendall CW, Marchie A, et al. The Garden of Eden-plant based diets, the
genetic drive to conserve cholesterol and its implications for heart disease in the 21st
6) Esselstyn CB. Updating a 12-year experience with arrest and reversal therapy for
coronary heart disease (an overdue requiem for palliative cardiology). Am J Cardiol.
1999;84: 339-41.

RELEVANT AMA AND AMA-MSS POLICY:

**Obesity as a Major Public Health Problem H-150.953**

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

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

**Healthy Lifestyles H-425.972**
Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
Whereas, More than 828,000 people over the age of 12 in the United States used heroin within the past year;¹ and

Whereas, A 2015 systematic review and meta-analysis of randomized control trials conducted in Switzerland, the Netherlands, Spain, Germany, Canada, and England, demonstrate benefits to supervised injectable heroin-assisted treatment (HAT) as a form of treatment for a subset of heroin-dependent patients who do not respond well to other treatment options;² and

Whereas, The British Medical Association, the Swiss Society of Addiction Medicine, and the European Monitoring Centre for Drugs and Drug Addiction have recently spoken in support of the use of HAT for heroin addiction,³,⁴,⁵ and

Whereas, Pharmaceutical-grade heroin (diamorphine) is registered as a medical product in 5 countries: Switzerland, the Netherlands, Germany, United Kingdom, and Denmark;² and

Whereas, Injectable HAT was found to be more effective than oral methadone;⁶ and

Whereas, Benefits of HAT included higher retention in treatment and lower mortality;² and

Whereas, In the 2014 Randomized Injectable Opioid Treatment Trial supervised injectable HAT was found to make significant reductions in street heroin use after 6 months of treatment in addicts that were previously unresponsive to treatment;⁷ and

Whereas, There is a greater improvement in health-related quality of life for patients with severe heroin dependence (particularly physical health) under HAT compared to methadone;⁶ and

Whereas, The health of chronic intravenous drug users who underwent a HAT plan was improved with a reduction in viral hepatitis compared to users who did not undergo the same treatment plan;⁹ and

Whereas, Patients on HAT (compared to those on methadone treatment) saw significant improvement in regard to medical and psychiatric status, economic status, employment situation, and family and social relations;⁹ and

Whereas, Treatment with supervised injectable HAT was shown to decline patients’ involvement with illicit and criminal activities;⁶,¹⁰,¹¹ and
Whereas, HAT may be more cost-effective due to lower estimated law enforcement costs compared to treatment with methadone alone for chronic, treatment-resistant heroin addicts; and

Whereas, current AMA policy states that methadone should not be the sole preferred agent for substance abuse treatment (H-120.937); and,

Whereas, current AMA policy encourages the continued study and implementation of appropriate treatments directed towards heroin overdose and treatment (H-95.956); therefore be it

RESOLVED, That our AMA support the study of the efficacy of diamorphine prescription programs for heroin-dependent patients.

Fiscal Note: Minimal, 4

Date Received:

References:


**RELEVANT AMA-MSS POLICY:**

**Promoting Prevention of Fatal Opioid Overdose (MSS100.010)**

AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for the education of health care workers and opioid users about the use AMA-MSS Digest of Policy Actions/ 19 of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11)

**Naloxone Administration and Heroin Overdose (MSS100.007)**

AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine. (MSS Rep A, A-05) (AMA Amended Res 526, A-06 Adopted [D- 95.987]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**RELEVANT AMA POLICY:**

**Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain H-55.991**

Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act.

**Treatment of Opioid Dependence D-120.953**

Our AMA will work to end the limitation of 100 patients per certified physician treating opioid dependence after the second year of treatment as currently mandated by the Drug Addiction Treatment Act.

**Harm Reduction Through Addiction Treatment H-95.956**

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

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

Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.

**Opioid Treatment and Prescription Drug Monitoring Programs D-95.980**

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

**Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979**

Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.

**Methadone Should Not Be Designated as the Sole Preferred Analgesic H-120.937**

Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private.

**Medical Direction of Methadone Treatment H-95.977**

Our AMA urges that the operation of methadone treatment programs be under the direction of physicians who are knowledgeable and competent in the treatment of addiction.
WHEREAS, Chronic pain has been identified as a “growing epidemic” which affects 100 million Americans and costs $630 billion per year; and
WHEREAS, Specific guidelines for treating chronic pain are not established and current family practice recommendations suggest treating chronic pain with a broad spectrum of potential solutions, such as cognitive behavioral therapy, exercise, and anti-inflammatories; and
WHEREAS, Acute pain is a peripheral form of tissue damage, compared to chronic pain, which has been proposed as a change to the central nervous system (CNS), in which biochemical changes that are distinctly different from acute pain occur; and
WHEREAS, Acute and chronic pain require unique treatment plans; and
WHEREAS, The use of opioids have continually shown to be effective in the treatment of acute pain, while as of 2014, there have been no studies conducted on the effectiveness of opioid usage in chronic pain management versus management without opioids; and
WHEREAS, Treating all pain as a uniform condition is “inadequate and incorrect” and there is a massive need to identify the biochemical mechanisms and treatment strategies best associated with different kinds of pain; and
WHEREAS, Large drug companies now focus on alterations of existing pain management products instead of expanding efforts towards non-opioid analgesics; and
WHEREAS, In a 2006 study, 81.5% of primary care physicians rated their undergraduate medical education in chronic pain as insufficient, with 54.7% rating their chronic pain training as residents as insufficient; and
WHEREAS, In 2010, only 34% of physicians felt comfortable in managing patients with chronic pain and only 1% found doing so satisfying7; and

WHEREAS, A recent Research America poll showed only 18% of respondents identified chronic pain as a major public health problem8; and

WHEREAS, This lack of public awareness of chronic pain contributes to the continued lack of federal research funding and the lack of private/philanthropic support for pain research and treatment8; therefore be it

RESOLVED, That our AMA recognize acute and chronic pain are discrete pathophysiological conditions that require specific and different forms of treatment; and be it further

RESOLVED, That our AMA support medical education as it relates to teaching and distinguishing acute versus chronic pain management; and be it further

RESOLVED, That our AMA use its Opioid Task Force to help raise public awareness of chronic pain as a major public health issue with focus on both the societal impact and personal suffering aspects of the disease.

Fiscal note: Significant, 11

Date received: 9/20/17

References:

RELEVANT AMA POLICY:

Model Pain Management Program For Medical School Curricula D-295.982
Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs.

Promoting Pain Relief and Preventing Abuse of Controlled Substances D-120.971
Our AMA will:
(1) urge the Drug Enforcement Administration (DEA) to publicly restate their commitment to balance in promoting pain relief and preventing abuse of pain medications;
(2) support an ongoing constructive dialogue among the DEA and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion;
(3) strongly urge that the DEA's upcoming recitation of the pertinent legal principles relating to the dispensing of controlled substances for the treatment of pain maintain a patient-centered focus, including reaffirmation of its previous interpretation of law to permit practitioners to issue a series of prescriptions marked "do not fill" until a later date; and
(4) strongly urge that the DEA should promulgate, in consultation with relevant medical specialty societies and patient advocacy groups, a rational and realistic set of FAQs to assist in providing education to health care practitioners and law enforcement and regulatory personnel about appropriate pain management, and measures to be taken to minimize drug abuse and diversion.

Pain Management Standards and Performance Measures D-295.966
Our AMA, through the Council on Medical Education, shall continue to work with relevant medical specialty organizations to improve education in pain management in medical schools, residency programs, and continuing medical education programs.

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (c) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in
Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit.

2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.

3. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

4. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based approach to addressing opioid-related morbidity and mortality.

5. Our AMA will advocate for increased funding for basic and translational pain research.
Resolved: Explicitly recommending education in emerging advanced technologies for medical students

Introduced by: Lucy Nam, Johns Hopkins University School of Medicine

Subject: Explicitly recommending education in emerging advanced technologies for medical students

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, A host of novel technologies are revolutionizing the nature of healthcare delivery, notably including machine learning, surgical robotics, high-throughput sequencing, and virtual reality; and

Whereas, Recent techniques in tissue engineering involving 3D-bioprinting are opening the door to an entirely new space of potential therapies and avenues for pharmaceutical development, which can address the massive shortage in available transplantable organs; and

Whereas, There have been significant advancements to image recognition technology using deep neural networks, a machine learning method that has been applied to a variety of consumer applications and social networks; and

Whereas, These image recognition technologies have been demonstrated to be effective for medical applications, in one study notably performing at the level of trained physicians at the detection and diagnosis of diabetic retinopathy; and

Whereas, The advent of high-throughput sequencing technologies in the past decade has facilitated an explosion of genetic data, including DNA and RNA sequencing technologies, and related techniques to conduct genome-wide assays of regulatory protein activity and chromatin accessibility to develop novel gene therapies; and

Whereas, Robot-assisted surgery presents an opportunity to enable wider access to surgical procedures across the world through a reduction in cost and training, and doctors training to be surgeons should be prepared to learn the techniques that complement the machines, and thus deliver the best care to patients; and

Whereas, Virtual reality (VR) technology is poised to be a critical tool for doctors and medical students to extend the range of scenarios they can experience in training; and

Whereas, It is highly likely that the nature of the careers of most medical students beginning today will be entangled with machine learning technologies such as deep learning technologies used to today to identify cancerous cells, and thus understanding their high-level uses and limitations is critical to being able to deploy treatments involving machine learning in a manner that optimizes the care given to patients; and
Whereas, These technologies require specialized training to understand their value and limitations with respect to healthcare delivery; and

Whereas, AMA policy (H-295.995) states that students should be educated in an increased breadth of clinical knowledge and that AMA MSS (295.044MSS) recognizes the future of medicine as an important educational goal for medical students; therefore be it

RESOLVED, That the AMA-MSS encourage partnerships in medical education between students with stakeholders of emerging advanced technologies to promote awareness in “future technologies” to provide a basic grounding in developing impactful technologies as part of their training, and be it further

RESOLVED, That our MSS formally establish support for HOD policy H-295.995, Recommendations for Future Directions for Medical Education.

Fiscal Note: Minimal, 3

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to
medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of ensuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted. (13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student. (14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students. (15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged. (16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice. (17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education. (18) Directors of residency programs should not permit medical students to make commitments to a residency program
prior to the final year of medical school. (19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For Physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines. (20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education. (21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs. (22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care. (23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public. (24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates. (25) Specialty boards should consider having members of the public participate in appropriate board activities. (26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities. (27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education. (28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued. (29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of
evaluation and to develop new methods having an acceptable degree of reliability and validity
should be supported. (30) U.S. citizens should have access to factual information on the
requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry
into graduate medical education programs, and other factors that should be considered before
deciding to undertake the study of medicine in schools not accredited by the LCME. (31)
Policies governing the accreditation of U.S. medical education programs specify that core
clinical training be provided by the parent medical school; consequently, the AMA strongly
objects to the practice of substituting clinical experiences provided by U.S. institutions for core
clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the
placement of any medical school undergraduate students in hospitals and other medical care
delivery facilities which lack educational resources and experience for supervised teaching of
clinical medicine. (32) Methods currently being used to evaluate the readiness of graduates of
foreign medical schools to enter accredited programs in graduate medical education in this
country should be critically reviewed and modified as necessary. No graduate of any medical
school should be admitted to or continued in a residency program if his or her participation can
reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality
of the educational experiences of other residents or of students in educational programs within
the hospital. (33) The Educational Commission for Foreign Medical Graduates should be
encouraged to study the feasibility of including in its procedures for certification of graduates of
foreign medical schools a period of observation adequate for the evaluation of clinical skills and
the application of knowledge to clinical problems. (34) The AMA, in cooperation with others,
supports continued efforts to review and define standards for medical education at all levels.
The AMA supports continued participation in the evaluation and accreditation of medical
education at all levels. (35) The AMA, when appropriate, supports the use of selected
consultants from the public and from the professions for consideration of special issues related
to medical education. (36) The AMA encourages entities that profile physicians to provide them
with feedback on their performance and with access to education to assist them in meeting
norms of practice; and supports the creation of experiences across the continuum of medical
education designed to teach about the process of physician profiling and about the principles of
utilization review/quality assurance. (37) Our AMA encourages the accrediting bodies for MD-
and DO-granting medical schools to review, on an ongoing basis, their accreditation standards
to assure that they protect the quality and integrity of medical education in the context of the
emergence of new models of medical school organization and governance.

Effective Education for the Future of Medicine 295.044MSS

Effective Education for the Future of Medicine: The AMA-MSS Governing Council will continue
to identify opportunities to present timely and relevant health policy information to medical
students.

Support of Business of Medicine Education for Medical Students 295.115MSS

Our AMA will encourage all US medical schools to provide students with a basic foundation in
medical business, drawing upon curricular domains referenced in Undergraduate Medical
Education for the 21st Century (UME-21), in order to assist students in fulfilling their
professional obligation to patients and society in an efficient, ethical, and cost-effective manner.

Educating Medical Students about the Pharmaceutical Industry 295.130MSS

AMA-MSS will ask the AMA to: (1) strongly encourage medical schools to include unbiased
curricula concerning the impact of direct-to-consumer marketing practice employed by the
pharmaceutical industry, as they relate to the physician-patient relationship; and (2) strongly
courage medical schools to include unbiased information in their curricula concerning the
pharmaceutical industry regarding (a) the cost of research and development for new
medications, (b) the cost of promoting and advertising new medications, and (c) the proportion
of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision-making process involved in prescribing medications specifically using evidence-based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (MSS Sub Res 15, I-04) (AMA Res 303, A-05 Adopted [D-295.955]) (Modified: MSS GC Report B, I-09) (D-295.955 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16)
Resolution: 87
(I-17)

Introduced by: Hari Iyer, Northeast Ohio Medical University

Subject: Reducing Exemptions and Increasing Vaccinations through Excellent Communication

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, The elimination of personal belief exemptions in the state of California has been correlated with an increase in the rate of utilization of medical exemptions, indicating the possibility that such legislation incentivizes parents to seek out physicians who will provide medical exemptions to replace prior personal belief exemptions; and

Whereas, West Virginia makes use of a State Immunization Officer who reviews physician requests for medical exemptions (including which vaccines, explanation, temporariness) and decides, using the most recent guidelines from the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP), whether to grant such an exemption, yielding a 0.01% (25 students) medical exemption rate in children attending public schools; and

Whereas, Vaccine-preventable illnesses still may cause severe morbidity, as did occur in Minnesota with the measles outbreak, which primarily afflicted the Somali immigrant community beginning in April, spurring collaboration between public health officials and local imams to communicate with the public and increase vaccination rates; and

Whereas, In patient communication, the difficulty and time-consuming nature of “countering vaccine hesitancy”, along with the importance of non-confrontational dialogue in the process, have been anecdotally established; and

Whereas, Continued research into best methods to communicate vaccine safety and effectiveness is needed; and

Whereas, In a study of 480 anti-vaccine sites, 42.1% of them cite mistrust in doctors and healthcare practitioners as a means of encouraging viewers to oppose vaccination, illustrating the potential sensitivity and utility of improving physician and medical student communication strategies on vaccination; and

Whereas, The mission of the AMA delineates a commitment to the betterment of public health; therefore be it

RESOLVED, That our AMA-MSS formally establish support for HOD policy H-440.830: Education and Public Awareness on Vaccine Safety and Efficacy; and be it further
RESOLVED, That the AMA and stakeholders encourage the consideration of state-specific legal exemptions from immunization requirements in providing physicians and medical students with guidance on effective immunization counseling communication practices; and be it further

RESOLVED, That the AMA discourage doctor shopping by actively opposing the practice of physicians granting medical exemptions to children who are not at risk of harm in line with up-to-date American Academy of Pediatrics (AAP), American Committee on Immunization Practices (ACIP), or American Academy of family Physicians (AAFP) recommendations

Fiscal Note: Significant, 10

Date Received: 9/20/17

References:

RELEVANT AMA AND AMA-MSS POLICY:

**H-440.830 Education and Public Awareness on Vaccine Safety and Efficacy**
1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (f) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

**H-440.970 Nonmedical Exemptions from Immunizations**
Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and
the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.

**440.051MSS A Comprehensive Education Strategy to Improve Vaccination Rates:** AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that underimmunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed at increasing the vaccination rate.

**440.035MSS Increasing Advocacy for and Public Awareness of the Lack of a Vaccine-Autism Link:** AMA-MSS will ask the AMA to ask the Office of the Surgeon General for a definitive repudiation of the link between developmental disorders, such as autism, and either thimerosal-containing vaccines or the MMR vaccine.

**440.027MSS Increasing Accessibility to Meningitis Protection:** (1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate students about the benefits of vaccination. (2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance.

**440.028MSS HPV Vaccine in Cervical Cancer Prevention Worldwide:** AMA-MSS will ask the AMA to: (a) urge physicians to educate themselves and their patients about HPV vaccination; (b) encourage the development and funding of programs targeted at reducing HPV transmission and screening for infection and precancerous cervical changes in developing countries; (c) intensify efforts to improve awareness and understanding about the availability and efficacy of HPV vaccinations in the general public; (d) encourage the integration of HPV vaccination into reproductive health care settings, including but not limited to routine reproductive health care visits for adults and adolescents; and (e) support the availability of the HPV vaccine to patient groups that benefit most from preventative measures, including but not limited to low-income and pre-sexually active populations.
Whereas, As of April 2017, Female physicians account for 34% of the workforce and 48% of all medical students;¹,² and

Whereas, According to a survey of over 36,000 licensed, full-time U.S. physicians who practice at least 40 hours per week, the average national gender gap among physicians is 26.5 percent, with female physicians on average making $91,284 less than the average male physician, after factoring in all specialties examined and regional differences;³

Whereas, Women physicians in academic medical institutions earn over $19,000 less than their male counterparts after adjusting for years of experience, faculty rank, and specialty;² and

Whereas, Even after adjusting for experience, faculty rank, and specialty, approximately 40% of the unadjusted difference in mean salaries between men and women is unexplained;² and

Whereas, The salary of a female who is a full time Professor is similar to that of a male who is a full time Associate Professor;⁴ and

Whereas, Medicare reimbursements for female healthcare providers are on average $18,000 less than male healthcare providers within 13 different specialties respectively, regardless of amount worked, level of productivity or years of experience, with differences in reimbursements more likely due to concomitant services or location;⁵ and

Whereas, The AMA (D-200.981), the American Medical Women’s Association and the American Association of Family Physicians recognize that physician gender pay gap is a concern;⁶,⁷ and

Whereas, The gender wage gap for doctors is significant across the country, including cities such as Charlotte, NC (33%), Pittsburgh, PA (30%), San Jose, CA (27%), Birmingham, AL (27%), and New York, NY (27%);⁵ and

Whereas, In addition to income discrimination towards females in medicine and the wider workforce, multiple studies since the mid-1990s have found that 15% to 43% of lesbian, gay, and bisexual (LGB) individuals report workplace discrimination;⁸ and

Whereas, Studies conducted between 1996 and 2006 find that 20% to 57% of transgender individuals report employment discrimination;⁹ and
Whereas, Comparisons of sexual orientation discrimination complaints from ten states demonstrate LGB complaint rates comparable to gender-based discrimination complaint rates; and

Whereas, The AMA in 2013 reaffirmed policy D-200.981 to encourage medical organizations to study gender differences in income and advancements and to develop programming to address the disparities; and

Whereas, The AMA policy D-200.981 also urges the medical community to monitor transparency in pay levels to identify and eliminate gender bias and promote gender equity; therefore be it

RESOLVED, That our AMA amend D-200.981 by addition as follows:

Our AMA: (1) encourages medical associations and other relevant organizations to study gender and lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQ+) differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist; (2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations; (3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender and LGBTQ+ bias and promote gender and LGBTQ+ equity throughout the profession; (4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender and LGBTQ+ parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender and LGBTQ+ disparities as a member benefit; (6) create programs to educate physicians, medical students and hospital administrators about gender-based and LGBTQ+ based income discrimination and how to combat it via educational resources including but not limited to CME sessions.

Fiscal Note: Significant, 12

Date Received: 

References:
2. Kaiser Family Foundation. Distribution of Medical School Graduates by Gender. 2015. http://www.kff.org/other/state-indicator/medical-school-graduates-by-gender/?dataView=1&currentTimeframe=0&selectedDistributions=female&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D


RELEVANT AMA AND AMA-MSS POLICY:

Gender Discrimination in Medicine 9.5.5
Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians. Collectively, physicians should actively advocate for and develop family-friendly policies that: (a) Promote fairness in the workplace, including providing for: (i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family; (ii) on-site child care services for dependent children; (iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations. (b) Promote fairness in academic medical settings by: (i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure; (ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research; (iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks; (iv) structuring the mentoring process through a fair and visible system. (c) Take steps to mitigate gender bias in research and publication.

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Gender Disparities in Physician Income and Advancement D-200.981
Our AMA: (1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist; (2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations; (3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency
in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession; (4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients.

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

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

Cultural Competency Training For Medical School Faculty, Staff, and Students Concerning Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Gender Nonconforming, and/or Born with Differences of Sexual Development 295.190MSS

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age. (MSS Res 03, A- 16)

Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses 65.010MSS

AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
Whereas, The Goldwater Rule is an ethical policy adopted by the American Psychiatric Association that states “a psychiatrist may share with the public his or her expertise about psychiatric issues in general” and “it is unethical for a psychiatrist to offer professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement [through public media]”;

Whereas, The Goldwater Rule was adopted to protect the patient, avoid embarrassment to the psychiatric profession, and de-stigmatize seeking of psychiatric care;

Whereas, The Goldwater Rule was written so that psychiatrists could speak in general terms about psychiatric issues, but should specifically refrain from publicly commenting on and claiming knowledge about a particular individual’s diagnosis;

Whereas, The Goldwater Rule remains relevant today, having been most recently invoked in the media in relation to commentaries surrounding public figures’ mental health;

Whereas, Existing AMA and AMA-MSS policies outline ethical obligations for the physician when discussing general medical information, but do not specify ethical obligations regarding specific medical cases or individual patients;

Whereas, In 2017 the Charlie Gard case was a highly publicized ethical and legal case where the parents of Charlie Gard, an infant born with a rare genetic disorder fought for experimental treatment over palliative care;

Whereas, Charlie Gard’s parents specifically sought advice from an American neurologist who admitted that his recommendations were theoretical and based on limited evidence, and after reviewing the patient’s records admitted that the neurological damage was more severe than he had thought, altering his medical recommendations;

Whereas, As the end of the court cases approached, the neurologist had still not examined or seen the patient; and

Whereas, Some medical ethicists have questioned whether a medical expert should offer their expert opinion without first seeing the patient and examining the evidence; and

Whereas, One of the medical ethicists suggested “we will never know whether or not it would have changed the evidence he gave at that time, but it would give us more confidence in that evidence if he had come and examined Charlie himself;” and
Whereas, a diagnostic conclusion is susceptible to error without the option of a direct examination or the opinion of a professional who has conducted a direct examination; and

Whereas, The AMA Principle of Medical Ethics 2.3.2 titled “Professionalism in the Use of Social Media” reminds physicians that public media actions can impact their reputation, their careers, and the public’s trust in the medical profession, therefore be it

RESOLVED, That our AMA consider it unethical for a physician to offer a professional opinion about specific medical cases on individual patients unless he or she has conducted an examination and has been granted proper authorization for a public media statement.

Fiscal Note: Moderate, 9

Date Received: 9/20/17

References:

3. Lenzer J. Do doctors have a “duty to warn” if they believe a leader is dangerously mentally ill? BMJ. 2017;356. doi:10.1136/bmj.j1087.

RELEVANT AMA AND AMA-MSS POLICY:

Code of Medical Ethics 3.1.5 - Professionalism in Relationships with Media

Ensuring that the public is informed promptly and accurately about medical issues is a valuable objective. However, media requests for information about patients can pose concerns about patient privacy and confidentiality, among other issues. Physicians who speak on health-related matters on behalf of organizations should be aware of institutional guidelines for communicating with media, where they exist. To safeguard patient interests when working with representative of the media, all physicians should:
(a) Obtain consent from the patient or the patient’s authorized representative before releasing information.
(b) Release only information specifically authorized by the patient or patient’s representative or that is part of the public record.
(c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician.
(d) Refer any questions regarding criminal activities or other police matters to the proper authorities.

**Ethical Physician Conduct in the Media D-140.957**
1. Our American Medical Association will report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication.
2. Our AMA will study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform.
3. Our AMA will release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

**140.030MSS Ethical Physician Conduct in the Media**
AMA-MSS (1) supports a report on the professional and ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) urges the AMA release a statement affirming the professional and ethical obligation of physicians in the media to provide quality medical advice transparent to supporting evidence and conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media; and (3) supports a study existing and potential disciplinary pathways for physicians who violate ethical responsibilities through their communication on a media platform. (MSS Res 25, A-15)
AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 90
(I-17)

Introduced by: Neil Jain, Rowan University School of Osteopathic Medicine; Sulman Mahmood, Aimin Mitwally, and Harsh Jain; Rowan University School of Osteopathic Medicine

Subject: Implementing Portable Breastfeeding Facilities in Public Premises

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Breastfeeding is imperative for infant development and maternal mental health; and

Whereas, The Centers for Disease Control and Prevention (CDC) states that more than 8 in 10 mothers begin breastfeeding their babies at birth, which demonstrates that mothers want to breastfeed; and

Whereas, A nationally marketing survey, SummerStyles, conducted in 2015 found that only 64 percent of U.S. adults believed that women should have the right to breastfeed in public places and 58 percent of Americans felt comfortable when women breastfeed their babies near them in public places; and

Whereas, 45 percent of U.S. adults have indicated that mothers who breastfeed have to compromise their lifestyle and freedom; and

Whereas, The CDC has identified several barriers to breastfeeding including inadequate space and equipment to breastfeed in workplaces and childcare centers; and

Whereas, Mothers have been asked to stop or leave premises when they have breastfed in public places, which have led them to feel embarrassed and fearful of being stigmatized; and

Whereas, Women have chose to feed infant formula to their child in lieu breastfeeding (CDC recommendation), to escape from embarrassment; and

Whereas, Mothers and families need community support to face the aforementioned barriers; and

Whereas, Although current AMA and AMA-MSS policies support breastfeeding and AMA Policy H-245.982 specifically encourages public spaces to provide designated areas for breastfeeding, there is no existing AMA-MSS policy or AMA policy pertaining to how to increase public facilities; and Whereas, Office of Women’s Health at the Department of Health and Human Services support portable lactation facilities; and

Whereas, Portable lactation facilities, resembling portable restrooms, are equipped with lactation pumps and provide appropriate privacy as well as accessibility to breastfeeding mothers and have already been nationally implemented in government facilities, hospitals, malls, airports, arenas, and other public spaces by Mamava Incorporated; therefore be it

...
RESOLVED, That our AMA promote the implementation of portable breastfeeding facilities in relevant public premises and at relevant public events; and be it further

RESOLVED, That our AMA will work with appropriate stakeholders such as Office of Women’s Health at the Department of Health and Human Services and Mamava to implement portable breastfeeding facilities; and be it further

RESOLVED, That our AMA will work with the aforementioned organizations in developing portable breastfeeding stations that are adequately equipped with the necessary instruments, space, and privacy.

Fiscal Note: Significant 12

Date Received: 9/20/17

References:

RELEVANT AMA AND AMA-MSS POLICY:

Relevant AMA Policy:
AMA Support for Breastfeeding, H-245.982 - states that “Our ama ...(d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breastfeeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.”

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

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

270.017MSS - Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities and Equipment for Breastfeeding: AMA-MSS will ask the AMA to support legislation encouraging and promoting breast feeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises. (MSS Sub Res 12, A-01) (AMA Res 243, A-01 Not Adopted) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)
Whereas, Consuming fish has many health benefits due in part to the high concentrations of omega-3 polyunsaturated fatty acids (PUFAs), including eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) present in many species;\textsuperscript{1,2} and

Whereas, Evidence demonstrates that consumption of omega-3 PUFAs is associated with fetal and infant neurodevelopment along with reduced incidence of cardiovascular disease, autoimmune diseases, multiple neurodegenerative diseases and a variety of cancers including prostate, renal, breast and colon cancer;\textsuperscript{3} and

Whereas, Humans synthesize a negligible amount of omega-3 PUFAs and must acquire them from their diet;\textsuperscript{3} and

Whereas, the USDA’s 2015-2020 Dietary Guidelines for Americans recommends consumption of at least 250 mg of EPA and DHA daily, especially for pregnant and breastfeeding women;\textsuperscript{4} and

Whereas, Consistent evidence demonstrates that the health benefits from consuming a variety of seafood in the amounts recommended outweigh the health risks associated with corresponding methyl mercury levels, a heavy metal found in seafood at varying levels;\textsuperscript{4} and

Whereas, There is over a 1,000-fold difference in DHA and EPA levels recorded in various fish depending on the species consumed, how it was prepared, and how it was raised;\textsuperscript{5} and

Whereas, The National Marine Fisheries Service (NMFS) and the United States Department of Agriculture (USDA) are responsible for the stewardship of national marine resources, including the management and conservation of U.S. fisheries;\textsuperscript{6,7} and

Whereas, Global fishing is believed to have reached its greatest yield in 1996 at 130 million metric tons, with each following harvest declining by about 1.2 million metric tons each year;\textsuperscript{8} and

Whereas, Decreasing wild fish harvests affect global food security, and are attributed to a wide variety of factors including population growth, rising incomes, overfishing, improved technology to catch seafood by large fishing fleets, illegal and unregulated fishing, poor fishery management, and the impacts of climate change;\textsuperscript{5,9,10} and
Whereas, Fishery collapses, defined as catches dropping below 10% of the recorded maximum, are accelerating with cumulative collapses reaching 65% in 2003, and extrapolation of the regression model predicting global collapse of all commercially exploited fish populations in 2048; and

Whereas, U.S. government agencies are working to expand the domestic aquaculture industry, which currently contributes less than one percent of global aquaculture production; and

Whereas, Existing AMA policy encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives (Stewardship of the Environment H-135.973); and

Whereas, Existing AMA policy in regards to the U.S. Farm Bill supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders (Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932); therefore be it

RESOLVED, That our AMA support state and federal policies that better integrate the National Marine Fisheries Service and the United States Department of Agriculture with U.S. public health agencies through means including but not limited to appointing public health representatives on these regulatory bodies; and be it further

RESOLVED, That our AMA support state and federal policies that increase the U.S. fish supply to meet current and foreseeable U.S. nutritional requirements through means including but not limited to increasing the number of U.S. fisheries and increasing the efficiency and sustainability of existing U.S. fisheries to optimize long-term yield; and be it further

RESOLVED, That our AMA reaffirm AMA policy H-150.932: Reform the US Farm Bill to Improve US Public Health and Food Sustainability.

Fiscal note: Minimal, 6

Date received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. Res. 215, A-13

Stewardship of the Environment H-135.973
The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning
and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. CSA Rep. G, I-89 Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402; A-10 Reaffirmation I-16

**Sustainable Food D-150.978**

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

**Food Safety - Federal Inspection Programs H-150.967**

Our AMA encourages the FDA and the U.S. Department of Agriculture to continue their efforts to assure the safety of the food supply. Inspection of meat, poultry, and seafood should be viewed as one component of an overall program for improving food safety. CSA Rep. L, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11

**Mercury and Fish Consumption: Medical and Public Health Issues H-150.947**

AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15

**Mercury in Food as a Human Health Hazard 150.013MSS**

(1) AMA-MSS will ask the AMA to (a) encourage that testing of mercury content in food, including fish, be continued by appropriate agencies, and laboratory reporting of results of mercury testing be updated and consistent with current Environmental Protection Agency and National Academy of Sciences standards; (b) encourage the Food and Drug Administration to
determine the most appropriate means of testing and labeling of all foods, including fish, to
determine mercury content; and (c) encourage that the results and AMA-MSS Digest of Policy
Actions/30 advisories of any mercury testing of fish should be readily available where fish are
sold, including labeling of packaged/canned fish. (2) AMA-MSS supports the AMA encouraging
physicians to educate their patients about the potential dangers of mercury toxicity in some food
and fish products, especially those that are well documented to contain mercury, and to advise
pregnant women to limit and parents to limit their children’s consumption of such
products. MSS Sub Res 34, A-03; Reaffirmed: MSS Rep E, I-08; Reaffirmed: GC Rep B-I-13

Mandatory Federal Inspection of Fresh Fish and Shellfish 150.005MSS
AMA-MSS will ask the AMA to support a federal action, regulatory or legislative as appropriate,
that would require mandatory safety inspection of handling of fresh fish and shellfish sold in the
Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10;
Reaffirmed: MSS GC Rep D, I-15
Whereas, medical students are more likely to exhibit symptoms of depression than the general public\(^1\); and

Whereas, 26.7% of medical students are depressed\(^2\), and 11.2% of medical students have suicidal ideation\(^3\); and

Whereas, of the depressed medical students only 15.7% report seeking care\(^4\); and

Whereas, 37% of depressed medical students cited lack of confidentiality as a barrier to seeking care, and 28% of depressed medical students cited fear of documentation on academic record as a barrier to seeking care\(^5\); and

Whereas, A study showed 20% of residents met the criteria for depression and 70% met the criteria for burnout\(^6\); and

Whereas, Current AMA policy addresses the importance of physician health and wellness and education thereof, it does not address the importance of health and wellness for medical students, residents, and fellows; therefore be it

RESOLVED, That our AMA amend policy H-405.961 by insertion as follows:

**H-405.961 Physician Health Programs**

Our AMA affirms the importance of medical student, resident, fellow, and physician health and the need for ongoing education of all physicians and medical students regarding medical student, resident, fellow, and physician health and wellness.

Fiscal Note: Minimal, 5

Date Received: 9/20/17

**References**


RELEVANT AMA AND AMA-MSS POLICY:

Providing Medical Services through School-Based Health Programs H-60.991
(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to
improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Depression and Physician Licensure D-275.974
Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for
assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

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

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students on an opt-out basis;

B. ensure anonymity, confidentiality, and protection from administrative action;

C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and

D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

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

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

**Medical Student Support Groups H-295.999**

(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.

(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

**Suicide Prevention Program for Medical Students 295.058MSS**

AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H-345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment 295.164MSS**

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

**Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS**

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)

**Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973**

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical
and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services... should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.

**Addressing Medical Student Mental Health Through Data Collection and Screening**

345.012MSS:
AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A-17 Adopted as Amended [appended to H-295.858])

**Support Groups 295.001MSS:**
Whereas, The Liaison Committee on Medical Education (LCME) which accredits United States medical schools defines a “fair and formal process for taking any action that may affect the status of a medical student” such that a “...student will be assessed by individuals who have not previously formed an opinion of the student’s abilities, professionalism, and/or suitability to become a physician”;¹ and

Whereas, Latino/a and black physicians received a disproportionate number of complaints to the Medical Board of California and had greater odds of complaints escalating to investigations, and Latino/a physicians had a greater probability of having an investigation result in disciplinary action in a study of 32,978 complaints to the Medical Board of California between 2003 and 2013;² and

Whereas, One study evaluating the effects of blinded peer review on scientific abstract acceptance found that it resolved statistically-significant bias against non-English speaking authors, international institutions, and less prestigious institutions;³ and

Whereas, In response to well-characterized racial disparities in grant funding, in which black and Asian applicants were significantly less likely to receive R01 research funding than white applicants, the NIH announced its intent to assess “whether grant reviewers are thinking about an applicant’s race at all, even unconsciously”, by “strip[ping] names, racial identification and other identifying information from some proposals before reviewers see them, and look[ing] at what happens to grant scores”;⁴,⁵ and

Whereas, The NIH’s Center for Scientific Review has also released plans to conduct an anonymous review study to investigate potential bias in peer review, which entails comparing anonymized to non-anonymized reviews and examining any resultant differences that could be attributed to race and sex awareness;⁶ and
Whereas, A study in which fabricated prospective students with names indicative of their gender and race sent emails to professors to discuss research opportunities demonstrated that professors were most responsive to students whose names indicated that they were Caucasian and male, especially professors at private universities and those in more lucrative fields; and

Whereas, A study of medical students in the Netherlands revealed that non-Dutch students were referred to the professional behavior board at a rate 2.86 times that of Dutch students, and noted that “(cultural) differences in communication styles may be a possible explanation for these students’ underperformance” and “more subjective grading in clinical training can lead to what is called ‘examiner bias’, which means that examiners have a more positive view on people who are similar to themselves”; and

Whereas, In a study conducted in the United Kingdom, minority medical students performed more poorly on an objective structured clinical examination than white students, and the authors observed that “the style of some students to distance themselves from patients reflects a medical model of consultation rather than a more social one preferred by examiners” and “students from ethnic minorities might be more likely than white students to use this style”; and

Whereas, The utilization of blind auditions for symphony orchestras resulted in a precipitous increase in the probability of selecting women; and

Whereas, All component groups of the admissions committee of the Ohio State University College of Medicine showed implicit white preference on the black-white implicit association test, with men and faculty members displaying greater levels of unconscious bias than women and students; therefore be it

RESOLVED, That our AMA advocate that all reviews of medical student professionalism and academic performance be conducted in a blinded manner; and be it further

RESOLVED, That our AMA send a letter to the Liaison Committee on Medical Education (LCME) advocating that blinded review of medical students be required of all LCME-accredited medical schools.

Fiscal Note: Significant, 12

Date Received: 9/20/17

References:


RELEVANT AMA AND AMA-MSS POLICY:

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients’ clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients’ health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

**Fostering Professionalism During Medical School and Residency Training D-295.983**

1. Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics.
   (b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism.
   (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees’ acquisition of professionalism.
   (d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism.

2. Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism.

**11.2.1 Professionalism in Health Care Systems**

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may
emerge in the future—can affect patients’ choices, the patient-physician relationship, and physicians’ relationships with fellow health care professionals. Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians’ exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented. Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
   (i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
   (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
   (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
   (iv) mitigate possible conflicts between physicians’ financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
   (i) provide care for patients with difficult to manage medical conditions;
   (ii) practice at their full capacity, but not beyond.
(f) Recognize physicians’ primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
(g) Are routinely monitored to:
   (i) identify and address adverse consequences;
   (ii) identify and encourage dissemination of positive outcomes.

All physicians should:
(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

295.123MSS Teaching and Evaluating Professionalism in Medical Schools: AMA-MSS will ask the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME- accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation process, examining teaching and evaluation of the competencies at LCME- accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME- accredited medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations. (MSS Res 10, A-04) (AMA Amended Res 304, A-05 Adopted [D-295.954]) (Reaffirmed: MSS GC Report B, I-09) (D-295.954 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16)
Introduction by: Prakhar Bansal, Omar Allam, and Shaan Kamal, University of Connecticut School of Medicine; Matthew Sagnelli, Brian Liang, University of Connecticut School of Medicine

Subject: Definition of a Physician and Physician as a Protected Term

Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

1 Whereas, The AMA does have existing policy on the usage and definition of the title of physician and affirms the designation of physician only to those who have completed a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” or equivalent degree following completion of the course of study from a school of medicine or osteopathic medicine and the AMA-MSS does not have any such policy; (H-405.969) and

2 Whereas, The definition of a “protected term” is that it is a phrase or title that has restrictions and requirements as to who may use it and the AMA-MSS does not recognize “physician” as a protected term; therefore be it

11 Resolved, That our AMA-MSS affirm the designation of physician only to those who have completed a “Doctor of Medicine” or a “Doctor of Osteopathic Medicine” or equivalent degree in the study of evidence based medicine following completion of the course of study from an accredited school of medicine or osteopathic medicine and further be it;

17 Resolved, That our AMA-MSS treat “physician” as a protected term.

Fiscal Note: Minimal, 4

Date Received: 9/20/17

References:


10. State, V. S. of. ADMINISTRATIVE RULES FOR NATUROPATHIC PHYSICIANS. Vermont Secretary of State Available at: https://www.sec.state vt.us/media/166567/NAT_Rules.pdf.

RELEVANT AMA AND AMA-MSS POLICY:

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association.
training program, or have not completed at least one year of accredited post-graduate US medical education.

**Definition of a Physician H-405.969**
1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.

**Clarification of the Title "Doctor" in the Hospital Environment D-405.991**
1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, "that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or
osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

**Physician and Nonphysician Licensure and Scope of Practice D-160.995**
Our AMA will: (1) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (2) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (3) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.

**Non-Physician Prescribing H-120.955**
1. Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.

2. Our AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.

**DVA Non-Physician Prescribing Authority H-120.959**
Our AMA will continue to pursue appropriate regulatory, legislative and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications.
Resolved: 95
(I-17)

Introduced by: Rijul Asri, Rutgers New Jersey Medical School; Alexander Mozeika, Rutgers New Jersey Medical School; Priya Kantesaria, Rutgers New Jersey Medical School

Subject: Hospital Reporting of Physician Satisfaction as a Metric of Wellness

Referred to: MSS Reference Committee
(Rachel Ekaireb, Kevin Qin, Co-Chairs)

Whereas, Physician burnout rates within private practice and academic centers remains high;¹ and
Whereas, Physician professional satisfaction is negatively linked to administrative policies, such as clinical autonomy and use of electronic health records;² ³ and
Whereas, Medical student and resident wellness is intimately linked to the administrative environment of academic and community medical centers;⁴ and
Whereas, Satisfaction measurements are most reliable and actionable when conducted by independent, public organizations;⁵ and
Whereas, Patient continuity and satisfaction is dependent, among other variables, on physician behavior, with patient dissatisfaction being associated with physician burnout;⁴ ⁷ ⁸ and
Whereas, Patient choice of physician is heavily influenced by public data and open-access internet ratings;⁹ and
Whereas, Patient discontinuity with a specific institution imposes additional costs on patients, hospitals, and the healthcare system;¹⁰ and
Whereas, Hospital policy change has been initiated as a response to publicly-available patient satisfaction surveys;⁵ and
Whereas, Current AMA and AMA-MSS policy does not address specifically the procurement of physician satisfaction metrics as an assessment of physician, resident, and medical student burnout; (H405.957) therefore be it
RESOLVED, That our AMA-MSS encourage policy change that requires the addition of physician-reported professional satisfaction metrics to surveys administered to hospitals by independent organizations; and be it further
RESOLVED, That our AMA-MSS support the establishment of an independent database specific for physician, resident, and medical student satisfaction that is accessible to healthcare professionals and students to determine working environments in which they would be most
successful, and that is easy to use by patients to determine where to procure care; and be it
further

RESOLVED, That our AMA-MSS support publishing independently-acquired physician
satisfaction data on a national, open-access, independently-maintained, internet-based
platform; and be it further

RESOLVED, That our AMA-MSS reaffirm that previous policies that asks for the implementation
of physician, resident, and medical student wellness programs, specifically policies D310.968,
H405.957, and D405.990, that ultimately improve professional satisfaction at all levels.

Fiscal Note: Minimal, 4

Date Received:

References:

1. Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician
   satisfaction and burnout at different career stages. Paper presented at: Mayo Clinic
   Proceedings2013.

   satisfaction and their implications for patient care, health systems, and health policy.
   Rand health quarterly. 2014;3(4).


4. Lombardi MJ. Fostering humanism in medicine: A mixed methods study on the influence
   of Humanism in Medicine workshops on medical student empathy. Rowan University;
   2016.

5. Dyrbye L, Shanafelt T. A narrative review on burnout experienced by medical students

6. Al-Abri R, Al-Balushi A. Patient satisfaction survey as a tool towards quality


8. Garvey KC, Kesselheim JC, Herrick DB, Woolf AD, Leichtner AM. Graduate medical
   education in humanism and professionalism: A needs assessment survey of pediatric
   gastroenterology fellows. Journal of pediatric gastroenterology and nutrition.
   2014;58(1):34.

   associated with using physician-rating websites: cross-sectional study. Journal of
   medical Internet research. 2013;15(8).

    Cost, Readmissions, and Patient Satisfaction. Journal of general internal medicine.
    2014;29(7):1004-1008.

RELEVANT AMA AND AMA-MSS POLICY:

Physician and Medical Student Burnout D310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

Access to Confidential Health Services for Medical Students and Physicians H295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees’ grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring
appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

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

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

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

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

**Educating Physicians About Physician Health Programs D405.990**

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.

**Programs on Managing Physician Stress and Burnout H405.957**
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, and when to seek professional assistance for stress-related difficulties.

2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Subject: Policy Sunset Report for 2012 AMA-MSS Policies
Presented by: Helene Nepomuceno, Chair
Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

INTRODUCTION

At the 1995 Medical Student Section (MSS) Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-l-95 and MSS GC Report C-A-00. Consequently, MSS policies automatically expire after 5 years unless action is taken by the Assembly to retain them.

The sunset mechanism for MSS policy was established for several reasons, including

• To facilitate the analysis of policy for internal consistency and relevancy to the changing environment;
• To assist in the identification of areas where additional policy is needed;
• To help identify and remove outmoded, duplicative, or inconsistent policies;
• To promote efficiency in Assembly deliberations; and
• To simplify the resolution-writing process by monitoring the body of policy to be researched.

The policy sunset mechanism conforms to the following procedures codified in MSS policy 630.044:

(1) Review of policies will be the ultimate responsibility of the GC; (2) policy recommendations will be reported to the MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism.

MSS POLICY REVIEW

The MSS GC conducted an extensive review of policies adopted or reaffirmed by the MSS Assembly in 2011 as well as policies whose most recent reaffirmation date was questionable, most notably years 1999 and 2009. Appendix 1 of this report contains a listing of the 107 total policies adopted or reaffirmed in 2012, the recommendation for retention or rescission, and a brief supporting rationale for that recommendation. Many of these policies called for a specific finite action, such as preparing a letter, amending a policy, creating a product, or conducting a study. Other policies have been superseded by relevant AMA or MSS policy. The remaining
policies contain general statements of policy that are still relevant, at least in part, and can be referenced by organizations or individuals seeking support for a particular issue.

**MSS POLICY CONSOLIDATION**

In addition to its review of policies set to sunset at I-17, the MSS GC undertook a consolidation effort on a single topic, as directed by 645.023MSS – Medical Student Section Policy Making Procedures. Accordingly, the recommendation for policy consolidation on the issue of *TBA* is included in Appendix 2 of this report.

**RECOMMENDATIONS**

Your AMA-MSS Governing Council recommends that the following be adopted and the remainder of the report be filed:

1. That the policies specified for retention in Appendix 1 of this report be retained as official, active policies of the AMA-MSS.

2. That the policy consolidation actions specified in Appendix 2 of this report be retained as official, active policies of the AMA-MSS.
### Appendix 1 – Policy Sunset Report Recommendations for 2012 AMA-MSS Policies

<table>
<thead>
<tr>
<th>Policy No.</th>
<th>Policy Description</th>
<th>GC Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 020.002MSS</td>
<td><strong>AIDS Education:</strong> AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils. (MSS Sub Res 4, A-87) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain– still relevant</td>
</tr>
<tr>
<td>3 050.002MSS</td>
<td><strong>Use of Blood Therapeutically Drawn from Hemochromatosis Patients:</strong> AMA-MSS will ask the AMA to advocate the acceptance of blood drawn therapeutically from patients with hemochromatosis as a measure to correct the shortage in the blood supply, provided that methods are in place to ensure the donor's altruistic intent to use the blood for transfusion. (MSS Sub Res 1, I-97) (AMA Res 504, A-98 Referred) (CSA Rep 1, A-99 Adopted) (Reaffirmed: MSS Rep</td>
<td>Retain– still relevant</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4</td>
<td>055.001MSS</td>
<td></td>
</tr>
</tbody>
</table>
Adolescent and Young Adult Cancer:  
(1) AMA-MSS encourages further research into the scientific basis, treatment, and diagnosis of Adolescent and Young Adult Cancers; and  
(2) AMA-MSS promotes education and research about the unique challenges to treating adolescents and young adults with cancer, and promote solutions to these challenges. (MSS GC Rep D, A-12) | Retain- Still Relevant |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>060.008MSS</td>
<td>Implementation and Funding a Childcare Setting: AMA-MSS will ask the AMA to encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients. (MSS Res 21, A-12) (AMA Res 701, A-13 Not Adopted)</td>
<td>Retain- Still Relevant</td>
</tr>
<tr>
<td>7</td>
<td>060.021MSS</td>
<td>Gender-Specific Rehabilitation Programs, Mental Health, and Educational Services for Girls in Juvenile Detention System: AMA-MSS will ask the AMA to work with appropriate organizations to evaluate gender-specific rehabilitation programs, mental health services, and educational services in juvenile detention centers. (MSS Sub Res 10, I-02) (AMA Amended Res 411, A-03 Adopted [H-170.967]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>8</td>
<td>065.007MSS</td>
<td>Removing Barriers to Care for Transgender Patients: AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician. (MSS Amended Res 11, I-07) (AMA</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>10</td>
<td>075.007MSS</td>
<td>Prevention of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use: AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to sexual orientation minorities. (MSS Late Res 1, I-02) (AMA Amended Res 732, I-02, Adopted [D-20.994]) (Amended: MSS Rep C, I-07) (D-20.994 Rescinded: CCB/CLRDP Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain - Still Relevant</td>
</tr>
<tr>
<td>11</td>
<td>075.007MSS</td>
<td>Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use: AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to sexual orientation minorities. (MSS Late Res 1, I-02) (AMA Amended Res 732, I-02, Adopted [D-20.994]) (Amended: MSS Rep C, I-07) (D-20.994 Rescinded: CCB/CLRDP Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain - still relevant</td>
</tr>
<tr>
<td>12</td>
<td>095.006MSS</td>
<td>Comprehensive Evidence-Based Drug Treatment in Prisons: AMA-MSS will ask the AMA to work with appropriate specialty societies to develop and promote legislative and policy initiatives that expand comprehensive evidence-based substance abuse treatment in federal, state and local prisons and jails. (MSS Res 38, A-12) (HOD Policies</td>
<td>Retain - Still Relevant</td>
</tr>
<tr>
<td>13</td>
<td>095.007MSS</td>
<td>Increased Advocacy for Needle Exchange Programs: AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows: H-95.958 Syringe and Needle Exchange Programs The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes. (MSS Res 21, I-12) (AMA Res 203, A-13 Adopted [H-95.958])</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>14</td>
<td>100.011MSS</td>
<td>Drug Shortages: AMA-MSS supports the Council on Science and Public Health annual Reports Report 7, A-12, “Drug Shortages Update,” that contains the following recommendations as follows: 1. Our AMA supports the recommendations of the 2010 Drug Shortage Summit convened by the American Society of Health System Pharmacists, American Society of Anesthesiologists, American Society of Clinical Oncologists and the Institute for Safe Medication Practices and work in a collaborative fashion with these and other stakeholders to implement</td>
<td><strong>Modify and Retain</strong>- The MSS still maintains the principles and concerns of 100.011MSS, however, the some points have been successfully accomplished and are now outdated policy</td>
</tr>
</tbody>
</table>
these recommendations in an urgent fashion.

2. Our AMA supports requiring all manufacturers of Food and Drug Administration approve drugs to give the agency advance notice (within 6 months or otherwise as soon as practicable) of anticipated voluntary or involuntary, permanent or temporary, discontinuance of manufacture or marketing of such a product.

3. Our AMA supports the creation of a task force to enhance the HHS Secretary’s response to preventing and mitigating drug shortages and to create a strategic plan to address ongoing aspects of drug shortages.

3. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.

4. The Council on Science and Public Health continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem.

5. Our AMA urges the development of a comprehensive federal report on the root causes of drug shortages. Such an analysis should include economic factors, including federal reimbursement practices, as well as contracting practices by market
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>participants on competition, access to drugs, and pricing (Sub MSS Res 41, A-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>115.002MSS</td>
<td>Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being: AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed. (MSS Res 24, A-12) (AMA Sub Res 904, I-12 Adopted [D-115.990])</td>
</tr>
<tr>
<td>16</td>
<td>115.002MSS</td>
<td>Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health literacy and Patient Well-being: AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>17</td>
<td>120.002MSS</td>
<td>clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed. (MSS Res 24, A-12) (AMA Sub Res 904, I-12 Adopted [D-115.990])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>18</td>
<td>120.010MSS</td>
<td>Written Medications Instructions for Chronic Multi-Drug Therapy: AMA-MSS will ask the AMA to encourage health professionals to provide patients on chronic, multi-drug therapy with concise written instructions regarding their medications, specifying dosages, dosing frequency, and possible interactions. (MSS Sub Res 34, A-97) (AMA Res 501, I-97, Referred) (CSA Rep 2, I-98 Adopted) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retain- Still Relevant</td>
</tr>
<tr>
<td>19</td>
<td>120.010MSS</td>
<td>Aligning Prescription Medication Renewals: AMA-MSS will ask the AMA to encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the travel barriers for prescription acquisition. (MSS Res 16, A-12) (AMA Res 801, I-12 Adopted [H-120.952])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td></td>
<td>Prescription Medications</td>
<td>Out-of-Hospital Do-Not-Resuscitate (DNR) Orders</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>20</td>
<td>prescription medications may reduce the travel barriers for prescription acquisition. (MSS Res 16, A-12) (AMA Res 801, I-12 Adopted [H-120.952])</td>
<td>Out-of-Hospital Do-Not-Resuscitate (DNR) Orders: AMA-MSS supports the rights of terminally and chronically ill patients to have their DNR orders honored by emergency personnel in all out-of-hospital settings in so far that adequate proof and documentation of the patients’ DNR status can be provided in an emergency situation (i.e., medic alert bracelet, etc.). (MSS Amended Sub Res 4, A-97) (Reaffirmed: MSS GC Rep B, I-02) (Reaffirmed: MSS GC Rep C, I-07) (Modified: MSS GC Rep C-I-12)</td>
</tr>
<tr>
<td>21</td>
<td>Retain- still relevant</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>23</td>
<td>145.009MSS</td>
<td>Regulation of Handgun Safety and Quality: AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns. (MSS Amended Sub Res 22, I-97) (AMA Res 235, I-97 Adopted [H-145.985]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>24</td>
<td>150.026MSS</td>
<td>Programs to Combat Food Deserts: AMA-MSS will ask the AMA to amend policy D-150.978 by insertion and deletion as follows: D-150.978 Sustainable Food &quot;Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the healthcare community and the public about the importance of healthy and ecologically sustainable food systems. (MSS Res 19, I-12) (AMA Res 204, A-13 Adopted [D-150.978])</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>25</td>
<td>160.025MSS</td>
<td>Poverty Screening as a Clinical Tool for Improving Health Outcomes: AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (MSS Res 20, I-12) (Amended AMA Res 404, A-13 Adopted [H-160.909])</td>
</tr>
<tr>
<td>Page</td>
<td>MSS</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>-------------</td>
</tr>
<tr>
<td>26</td>
<td>170.010MSS</td>
<td>Abstinence-Only Education and Federally Funded Community-Based Initiatives: AMA-MSS supports initiatives to: (1) extend AMA support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence. (MSS Res 23, I-04) (AMA Amended Res 834 Adopted [H-170.968]) (Amended: MSS Late Res 1, A-12)</td>
</tr>
<tr>
<td>27</td>
<td>170.013MSS</td>
<td>Public School Screening for Childhood Obesity: AMA-MSS will ask the AMA to (1) encourage research and evaluative studies to develop a unified, evidence-based tool to accurately determine youth and adolescent weight status; and (2) encourage wide-scale, comprehensive, school-based obesity prevention that includes didactic curriculum, nutrition standards, physical education programs, and parent and teacher-involvement. (MSS GC Report E, A-07) (AMA Policy Reaffirmed in Lieu of AMA Res 803) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>#</td>
<td>MSS Code</td>
<td>Description</td>
</tr>
<tr>
<td>----</td>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>180.012MSS</td>
<td>Expanding Post-Mastectomy Options for Cancer Survivors: AMA-MSS will ask the AMA to recommend that third party payors provide coverage and reimbursement for medically beneficial breast cancer treatments including but not limited to prophylactic contralateral mastectomy. (MSS Res 11, A-02) (AMA Amended Res107, A-03 Adopted [H-55.978]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep C, I-12)</td>
</tr>
<tr>
<td>29</td>
<td>180.014MSS</td>
<td>Antitrust Exemption for Health Insurance Companies: AMA-MSS will ask the AMA to urge federal authorities to oppose antitrust exemption status for health insurance companies. (MSS Res 22, A-12)</td>
</tr>
<tr>
<td>30</td>
<td>200.015MSS</td>
<td>Supporting the Expansion of U.S. Residency Programs: AMA-MSS supports increases in the number of residency positions according to AMA workforce studies, where such increases would not undermine existing physician residency positions in any of the states. (MSS Amended Sub Res 1, I-07) (Reaffirmed: MSS GC Report C, I-07)</td>
</tr>
<tr>
<td>31</td>
<td>200.016MSS</td>
<td>Increasing Medical School Class Sizes: AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (MSS Sub Res 14, I-07) (AMA Res 309, A-08 Adopted [D-295.938]) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>32</td>
<td>245.011MSS</td>
<td>Protecting A Mother’s Right to Breastfeed: AMA-MSS supports state legislation that clarifies and enforces a mother’s right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother’s right to breastfeed in a public place. (MSS Res 15, A-02) (Reaffirmed: MSS Rep C, I-07)</td>
</tr>
<tr>
<td>33</td>
<td>245.018MSS</td>
<td>Revision of Resuscitation Policies for Premature Infants Born at the Cusp of Viability: AMA-MSS supports programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (MSS Sub Res 9, A-12)</td>
</tr>
<tr>
<td>34</td>
<td>245.019MSS</td>
<td>Support for Medicaid Reimbursement of Neonatal Male Circumcision: AMA-MSS will ask the AMA to (1) encourage state Medicaid reimbursement of neonatal male circumcision; and (2) update current policy to support the general principles of the revised 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads “Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure’s benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV.” (MSS Res 30, I-12) (AMA Res 503, A-13 Adopted [H-60.945])</td>
</tr>
<tr>
<td>35</td>
<td>250.017MSS</td>
<td>Medical Tourism: AMA-MSS supports informing patients about potential risks and benefits of going abroad to receive medical treatment. (MSS Resolution 1, A-07) (Reaffirmed: MSS</td>
</tr>
<tr>
<td></td>
<td>250.018MSS</td>
<td>Essential Medicines for the Developing World: AMA-MSS will ask the AMA to (1) support universities engaging nontraditional partners in order to create new opportunities for neglected disease drug development, including public-private partnerships, grant-making organizations, nonprofits, and developing-world research institutions; and (2) support the protection of fair access to essential medicines in developing countries. (Sub MSS Res 4, I-07) (AMA Res 515, A-08 Adopted [H-100.963]) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>250.023MSS</td>
<td>Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief: AIDS Relief: AMA-MSS (1) supports the efforts of the Global Health Service Partnership to strengthen African health care workforces; and (2) recognizes the benefits of including loan repayment in the Global Health Service Partnership funded from a variety of sources. (MSS GC Rep E, A-12)</td>
</tr>
<tr>
<td></td>
<td>250.026MSS</td>
<td>Research and Monitoring to Ensure Ethics of Global Health Programs: AMA-MSS will ask that our AMA amend Policy H-250.993 by insertion and deletion as follows: H-250.993 Overseas Medical Education Developed by US Medical Associations The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the</td>
</tr>
</tbody>
</table>
world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences, are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measureable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives.


Opposing Legislation of Medical Procedures: AMA-MSS strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient. (MSS Amended Sub Late Res 1, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07)
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>270.013MSS</td>
<td>Legislation of Medical Procedures: AMA-MSS will ask the AMA to work to ensure that if legislation seeks to regulate a medical procedure, the bill language utilizes standard medical terminology recognized by physicians to describe the procedure precisely. (MSS Amended Sub Res 17, I-97) (AMA Amended Sub Res 203, A-98) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>41</td>
<td>270.019MSS</td>
<td>Implementation of Automated External Defibrillators in High School and College Sports Programs: AMA-MSS will ask the AMA to (1) support state legislation and/or state educational policies encouraging each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator (AED) and trained personnel on its premises; and (2) support state legislation and/or state educational policies encouraging athletic coaches, sports medicine personnel, and student athletes to be trained and certified in CPR, AED, basic life support, and recognizing the signs of sudden cardiac arrest. (MSS Sub Res 5, I-07) (AMA Res 421, A-08) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Reference</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>42</td>
<td>270.025MSS</td>
<td>Protecting the Patient and Physician Relationship from Legislative Regulations: AMA-MSS (1) opposes legislation that requires physicians to perform medical procedures without valid medical indication or contrary to standards of care, especially as it concerns mandates to perform fetal ultrasounds on patients; and (2) opposes legislation that mandates specific counseling by physicians to patients, including mandatory viewing and description of fetal ultrasound images or required listening of fetal heart sounds. (MSS Res 10, A-12)</td>
</tr>
<tr>
<td>43</td>
<td>295.011MSS</td>
<td>Regulation of Medical Student Educational Opportunities: AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (AMA Res 142, I-87 Adopted [H-295.974]) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>45</td>
<td>295.111MSS</td>
<td>State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam: AMA-MSS will ask the AMA to: (a) commend the LCME for making clinical skill competencies a priority, (b) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and (c) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the matriculation requirements for the conferring of an MD degree. (MSS Late Res 1, A-02) (AMA Sub Res 308, A-02, Adopted [D-295.968]) (Amended: MSS Rep C, I-07) (D-295.968 Rescinded: CCB/CLRPD Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
<tr>
<td>46</td>
<td>295.113MSS</td>
<td>Clinical Skills Assessment as Part of Medical School Standards: AMA-MSS will ask the AMA to strongly urge the LCME and AOA to modify their accreditation standards as soon as possible to require that medical schools administer a rigorous and consistent assessment of clinical skills to all students as a requirement for advancement and graduation; (MSS Em. Res 1, I-02) (AMA Sub Res 821, I-02 [D-295.965]) (Amended: MSS Rep C, I-07) (D-295.965 Rescinded: CCB/CLRPD Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12)</td>
</tr>
</tbody>
</table>

Retain- While resulting AMA HOD policy (D-295.968) was rescinded by a report 10 years later (CCB/CLRPD Rep 4, A-12, ) the principles in this policy are still supported by the MSS, and they provide important context for 275.011MSS and the ongoing struggle against Step 2 CS. I think it's important to emphasize that the request in 295.111MSS(c) has not been accomplished and the MSS is not satisfied with the current state of affairs.

Sunset- The action was accomplished. The LCME has a standard (ED-37) that requires observation of core clinical skills. Note, AMA policy D-295.965 rescinded.
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>47</strong></td>
<td><strong>295.141MSS</strong></td>
<td>Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students: (1) AMA-MSS will ask the AMA to recognize that inter-professional education and partnerships are a top priority of the American medical education system; (2) AMA-MSS will ask the AMA to explore the feasibility of the implementation of LCME and AOA accreditation standards requiring inter-professional training in medical schools. (MSS GC Report A, A-07) (AMA Res 308, A-08 Adopted as Amended [D-295.934]) (Modified: MSS GC Rep C, I-12) (Reaffirmed: GC Rep B, I-13)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td><strong>48</strong></td>
<td><strong>295.142MSS</strong></td>
<td>Communication and Clinical Teaching Curricula: (1) AMA-MSS (a) supports the development of formalized medical teacher training for residents and attending faculty and (b) will ask the AMA to establish policy supporting the development of formalized medical teacher training for residents and attending faculty. (MS GC Report B, A-07) (AMA Res 804 Referred) (Modified: MSS GC Rep C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td><strong>49</strong></td>
<td><strong>295.143MSS</strong></td>
<td>Patient Safety Curriculum: AMA-MSS will ask the AMA to explore the feasibility of the Liaison Committee on Medical Education (LCME) including the requirement of patient safety training in medical school accreditation. (MSS GC Report C, A-07) (AMA Amended Res 801, I-07 Adopted [D-295.942]) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Sunset- As this was adopted by the HOD (see [295.942]) the feasibility was exhausted by the LCME Executive Committee and LCME. Per LCME policy, accreditation is not issue-based, but the LCME does ask if patient safety topics are covered at the medical school, and when/where those classes are utilized</td>
</tr>
<tr>
<td>50</td>
<td>295.144MSS</td>
<td>Support for the Family and Relationship During Medical School Residency: (1) AMA-MSS will work with the RFS, the AMA Alliance, and other interested organizations to (a) urge medical schools and residency programs to provide access to and encourage use of relationship counseling; (b) encourage medical schools and residency programs to offer workshops, activities, or lectures regarding the balance of family life with medical training and practice; and (c) promote opportunities for student and resident spouses and partners to become involved in the medical community, particularly through the AMA Alliance. (MSS Amended Res 13, I-07) (Modified: MSS GC Rep C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>51</td>
<td>295.166MSS</td>
<td>Expanding Clerkship Site Access to Include US Medical Schools Undergoing Accreditation: AMA-MSS will ask the AMA to amend Policy D-295.320 by insertion as follows: D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education Our American Medical Association will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies. (MSS Res 3, A-12)</td>
<td>Retain- Still relevant</td>
</tr>
<tr>
<td>52</td>
<td>295.167MSS</td>
<td><strong>Quality Improvement Education in Medical Schools and Residency Programs:</strong> AMA-MSS will (1) advocate to medical school deans for the inclusion of quality improvement education in medical school curricula; (2) encourage the American College of Medical Quality, the Association of American Medical Colleges, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, the Commission on Osteopathic Colleges Accreditation, and other relevant bodies to develop a basic set of core competencies in medical quality improvement that all medical school curricula should include; (3) encourage the American College of Medical Quality and other appropriate organizations to develop a guideline curriculum in medical quality improvement to be made available to medical schools; and (4) work with relevant parties to monitor the national implementation of quality improvement education in medical school curricula and report back to the Medical Student Section. (MSS Res 4, A-12)</td>
<td>Retain- Still relevant</td>
</tr>
<tr>
<td>53</td>
<td>295.168MSS</td>
<td><strong>Expansion of Medical Spanish in US Medical Schools:</strong> AMA-MSS will encourage the AAMC, LCME, COCA, and AOA to identify and evaluate existing ways that schools incorporate medical Spanish and other non-English languages into their curricula and report successful strategies for improved proficiency to be used as guidelines for US accredited medical schools. (MSS Res 6, A-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>Page</td>
<td>Code</td>
<td>Description</td>
<td>Decision</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>54</td>
<td>295.169MSS</td>
<td><strong>Eliminating Legacy Admissions:</strong> AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the ACOM to remove any questions on secondary applications pertaining to legacy status. (MSS Res 8, A-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>55</td>
<td>295.170MSS</td>
<td><strong>Supporting Two-Interval Grading Systems for Medical Education:</strong> AMA-MSS acknowledges the benefits of a two-interval grading system in medical colleges and universities for the non-clinical curriculum.</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>56</td>
<td>295.171MSS</td>
<td><strong>Health Policy Education in Medical Schools:</strong> (1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and (2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies. (GC Rep B, A-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>57</td>
<td>295.172MSS</td>
<td><strong>Insurance Education for Medical Students:</strong> AMA-MSS will ask the AMA to work with the AAMC, AACOM, LCME, and COCA to encourage integration of medical educational curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician’s role in obtaining affordable care for patients. (MSS Res 5, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>58</td>
<td>295.173MSS</td>
<td>Policy and Advocacy Rotations for Medical Students: AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies. (MSS Res 6, I-12) (Sub AMA Res 301, A-13 Adopted [H-295.864])</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>59</td>
<td>305.041MSS</td>
<td>Recognizing Dependent Care Expenses in Determining Graduate Medical Education: AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, health care, and dependent care for all dependents. (MSS Amended Sub Res 9, A-97) (AMA Amended Res 205, I-97 Adopted [305.941]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>60</td>
<td>305.043MSS</td>
<td>Tax Exemption for National Health Services Corps Scholarship: AMA-MSS supports federal legislation that will assure that tax-exempt status is returned to the direct medical school expense portion of the National Health Service Corps Scholarship program. (MSS Late Res 4, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>61</td>
<td>305.049MSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizing Dependent Care Expenses In Determining Medical Education Financial Aid: (1) AMA-MSS will ask the AMA to: (a) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the &quot;cost of attendance&quot; and as an educational expense for the purposes of student budgets and financial aid in medical schools; (b) encourage medical schools to include dependent health insurance, dependent care, and dependent living expenses as part of the &quot;cost of attendance&quot; and as an educational expense for the purposes of student budgets and financial aid; and (c) ask its Council on Medical Education, Section on Medical Schools Academic Leadership Section, and Women's Physician Congress Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses; (2) AMA-MSS supports the inclusion of dependent care, health insurance, and living expenses in medical student financial aid budgets. (MSS Res 12, A-02) (AMA Amended Res 301, A-03 Adopted [D-305.986]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Modify and Retain-the title 'Section on Medical Schools; has been updated to Academic Physician Section, and the Women's Physician Congress has been updated to the Women Physician Section.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>305.060MSS</td>
<td>Solutions to Tackling the Increasing Cost of Medical Education: AMA-MSS will ask the AMA to (a) support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students; and (b) support policies that ensure that all information related to the allocation of funds from tuition and fees increases be disclosed to all prospective and current medical students for each respective medical school campus; (2) AMA-MSS will work to develop print and electronic resources for our local chapters to utilize on their campuses to encourage their medical school deans to adopt policies that ensure transparency in medical school tuition and fees increases; (3) The AMA-MSS Governing Council will (a) continue to work with our AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), and the AAMC Organization of Student Representatives (OSR) to encourage medical schools to adopt policies that ensure that all increases to medical school tuition and fees go towards direct improvements to medical student education. (MSS Amended Report G, A-07) (AMA Sub Res 310, A-08 Adopted) (Modified: MSS GC Rep C, I-12) (Reaffirmed: GC Rep B, I-13)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>63</td>
<td>305.061MSS</td>
<td>Student Loan Empowerment: AMA-MSS will ask the AMA to support legislation that requires medical schools to inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (MSS Amended Res 16, I-07) (AMA Res 307, A-08, Adopted as Amended [H-</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>295.869] (Reaffirmed: MSS GC Report C, I-12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transparency In Medical Student Financial Aid Reporting: AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants by encouraging medical colleges to provide additional data to students and applicants including but not limited to: (1) average debt incurred in medical school for graduating students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles (2) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution. (MSS Res 1, A-12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retain- still relevant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>305.074MSS</td>
<td>Reducing the Financial and Educational Costs of Residency Interviews: That our AMA consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, and (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews. And that the AMA-MSS consider the following strategies to address the high cost of interviewing for residency: (a) considering producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (b) creating and/or promote specific websites related to med student travel, and (c) providing or recommending an online forum where students can accommodate other medical students who are interviewing in their area. (Sub Res 2, A-12) (GC Rep A, A-14)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>66</td>
<td>305.075MSS</td>
<td>Retaining Public Service Loan Forgiveness: AMA-MSS will ask the AMA to (1) oppose the reduction of medical student and physician benefits or the creation of more stringent requirements for qualification under Public Service Loan Forgiveness; and (2) support the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness. (MSS Res 7, I-12) (Amended AMA Res 304, A-13 Adopted)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>Page</td>
<td>Code</td>
<td>Description</td>
<td>Retain still relevant</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>67</td>
<td>305.076MSS</td>
<td>Collaborative Efforts to Reduce Federal Loan Interest Rate: AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate. (MSS Res 10, I-12) (Amended AMA Res 302, A-13 Adopted [D-305.984])</td>
<td>Retain still relevant</td>
</tr>
<tr>
<td>68</td>
<td>305.077MSS</td>
<td>Increasing Public Service Opportunities for Specialists: AMA-MSS will ask the AMA to (1) encourage the National Health Service Corps and other relevant stakeholders to expand their scope and encourage the participation of specialists in order to ensure the provision of services in underserved communities; (2) work with state and federal governments, medical schools, the AAMC, and other relevant entities to encourage new loan forgiveness programs for specialists treating underserved patient populations; and (3) that our AMA urge states who opt-out of the ACA expansion of Medicaid to still comply with the increased reimbursement schedule for specialists treating Medicaid patients. (MSS Res 12, I-12) (AMA Policies D-200.978, D-200.980, D-200.982, D-200.985, H-200.954, D-305.960, D-305.973, D-305.975, D-305.979, D-305.993 and H-305.928 Reaffirmed in Lieu of Res 202, A-13)</td>
<td>Retain still relevant</td>
</tr>
<tr>
<td>69</td>
<td>310.019MSS</td>
<td>Increasing Public Service Opportunities for Specialists: AMA-MSS will ask the AMA to strongly encourage residency programs to inform applicants in a timely manner about their interview status and provide a time frame of notification dates in the application materials. (MSS Sub Res 26, A-97) (AMA Res 302, I-97 Adopted [H-310.998]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain still relevant</td>
</tr>
<tr>
<td>71</td>
<td>310.021MSS</td>
<td><strong>Promoting Resident Involvement in Organized Medicine:</strong> AMA-MSS encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and organized medicine conferences. (MSS Sub Res 13, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>72</td>
<td>315.001MSS</td>
<td><strong>Patient Confidentiality and Government Investigations:</strong> AMA-MSS opposes the implementation of federal legislation that would enable any government agency or representative of such agency to access a patient’s medical records without the patient’s knowledge and consent or court order. (MSS Amended Sub Res 11, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>73</td>
<td>315.002MSS</td>
<td><strong>Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals:</strong> AMA-MSS supports added safeguards, such as audits or “break the glass” access, for medical student records when those records are placed in the same system used for patients at the school’s affiliated hospitals. (MSS Res 13, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>74</td>
<td>350.013MSS</td>
<td>Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations: AMA-MSS will ask the AMA to encourage the National Institutes for Mental Health (NIMH) and local health departments to examine national and regional variations in psychiatric illnesses among immigrant and minority populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations. (Sub Res 2, A-12) (GC Rep A, A-14)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>75</td>
<td>360.001MSS</td>
<td>Increasing the School Nurse to Student Ratio: AMA-MSS will ask the AMA to (1) encourage state medical societies and organizations, such as the National Association of School Nurses and other stakeholders, to advocate at all levels for adequate funding of school nurse positions; and (2) encourage public schools, private schools, and other relevant organizations to employ school nurses in a manner that complies with CDC recommended nurse-to-student ratios. (MSS Res 23, A-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>76</td>
<td>370.003MSS</td>
<td>Organ Donation and Transplants: AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>77</td>
<td>370.011MSS</td>
<td>Investigating the Possibility of a Unified Living Donor Kidney Registry: AMA-MSS will encourage the AMA to support the study of how to develop a unified, nationwide living kidney donor registry and advocate for public and private funding of such studies to reach the long term goal of establishing a unified registry. (MSS Res 24, I-12) (AMA Res 2, A-13 Referred for Decision)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>78</td>
<td>370.012MSS</td>
<td>Organ Donation Education Programs in Driver Training Programs: AMA-MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs. (MSS Res 29, I-12) (Policy H-370.984 Adopted as Amended in Lieu of AMA Res 3, A-13)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>79</td>
<td>420.005MSS</td>
<td>Inclusion of Folic Acid Supplements in the Supplemental Nutrition Program: AMA-MSS will ask the AMA to (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs. (MSS Res 20, A-12) (Policy D-150.983, D-150.987, D-150.981, H-150.937, H-150.933, H-150.944, H-150.953, H-150.960, H-440.902 and D-440.954 Reaffirmed in Lieu of AMA Res 201, A-13)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>Page</td>
<td>MSS Code</td>
<td>Description</td>
<td>Retain Status</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>80</td>
<td>435.008MSS</td>
<td>Error Disclosure and Physician Apologies: AMA-MSS supports (1) full disclosure of medical errors; and (2) legislation that allows a physician to make an expression of apology, regret, sympathy, commiseration, condolence, or compassion to a patient or a patient's family without it constituting an admission of physician liability for any purpose. (MSS Res 6, A-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>81</td>
<td>440.017MSS</td>
<td>Reducing the Risk of the Flight-Associated Venous Thromboembolism: AMA-MSS will ask the AMA to work with and encourage the Federal Aviation Administration (FAA) and the airline industry to alert passengers to the flight-associated risk of deep vein thrombosis and to provide specific recommendations to passengers regarding ways to reduce their flight-associated risk for DVT. (MSS Res 3, A-02) (AMA Res 406, A-03 Referred) (CSA Rep 4, A-04 Adopted [D-45.998]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>82</td>
<td>440.018MSS</td>
<td>Childhood Obesity as a Public Health Epidemic: AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>Page</td>
<td>MSS Code</td>
<td>Issue Description</td>
<td>Retain Status</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>-------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>85</td>
<td>440.041MSS</td>
<td>Accounting for Socioeconomic Status in Clinical and Public Health Research: AMA-MSS will ask the AMA to study the literature regarding the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards. (MSS Res 15, I-12) (Amended AMA Res 502, A-13 Adopted)</td>
<td>Retain - still relevant</td>
</tr>
<tr>
<td>86</td>
<td>440.041MSS</td>
<td>Accounting for Socioeconomic Status in Clinical and Public Health Research: AMA-MSS will ask the AMA to study the literature regarding the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards. (MSS Res 15, I-12) (Amended AMA Res 502, A-13 Adopted)</td>
<td>Retain - still relevant</td>
</tr>
<tr>
<td>87</td>
<td>440.042MSS</td>
<td>Permitting Sunscreen in Schools: AMA-MSS will ask the AMA to (1) support the exemption of sunscreen from over-the-counter medication possession bans in schools and to encourage all schools to allow students to bring and possess sunscreen at school without restriction; and (2) encourage schools to allow teachers to provide students with sunscreen, without requiring the teacher to assist in application. (MSS Res 18, I-12) (Amended AMA Res 403, A-13 Adopted [H-460.980])</td>
<td>Retain - still relevant</td>
</tr>
<tr>
<td>88</td>
<td>460.008MSS</td>
<td>Support for Increased Regulation in Tissue Procurement: AMA-MSS will ask the AMA to (1) support efforts by the FDA, the American Association of Tissue Banks, CDC, and other appropriate establishments to institute a uniform system of tissue tracking and a national database of tissue registry for tissues intended for nonclinical scientific and educational purposes; and (2) reaffirm AMA Policy H-370.988 – Regulation of</td>
<td>Retain - still relevant</td>
</tr>
<tr>
<td>89</td>
<td>480.010MSS</td>
<td>Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician Patient Relationship: AMA-MSS (1) supports our AMA urging the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and (2) supports our AMA seeking regulatory guidance from the DHHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services. (Sub Res 13, A-12)</td>
<td>Retain- still relevant</td>
</tr>
</tbody>
</table>

<p>| 90 | 480.011MSS | Use of Integrated Pre-hospital Electronic Patient Care Reports for Pre-hospital Healthcare Providers: AMA-MSS will ask the AMA to support legislation incentivizing the comprehensive use of integrated electronic patient care reports by EMTs and paramedics for better cross communication, and to standardize the flow of information from pre-hospital to hospital. (MSS Res 14, A-12) | Retain- still relevant |</p>
<table>
<thead>
<tr>
<th>Row</th>
<th>MSS Number</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>91</td>
<td>480.012MSS</td>
<td>Preserving the Role of Physicians and Patients in the Evolution of Health Information: AMA-MSS supports increasing the number of funded positions at all levels of graduate, medical, and allied health professional training in medical informatics to a level commensurate with current Health Information Technology (HIT) spending through mechanisms including, but not limited to, student research positions funded by National Institutes of Health (NIH) T and F programs. (MSS Res 14, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>93</td>
<td>490.023MSS</td>
<td>Revising AMA Policy to Better Define Tobacco Products: AMA-MSS will ask the AMA to revise policies H-495.989, D-495.999, H-495.988, and H-490.914 to explicitly define “tobacco products” as “including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/waterpipe tobacco.” (MSS Res 22, I-12) (AMA Res 402, A-13 Adopted [H-490.914, H-495.988, H-495.989])</td>
<td>Sunset- effectively changed in relevant AMA policies</td>
</tr>
<tr>
<td>94</td>
<td>500.004MSS</td>
<td>Picture-Based Warnings on Tobacco Products: AMA-MSS will ask the AMA to support appropriate legislation requiring picture-based warning labels on tobacco products produced in, sold in or exported from the United States. (MSS Res 4, A-02) (AMA Res 407, A-03 [H-495.990]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>Page</td>
<td>MSS Number</td>
<td>Description</td>
<td>Recommendation</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>95</td>
<td>505.009MSS</td>
<td>Community Enforcement of Restrictions on Adolescent Tobacco Use: (1) AMA-MSS will support the development and distribution of educational materials designed to educate members and the public regarding FDA regulations on reporting sales of tobacco to minors. (2) AMA-MSS believes that these materials (which may include but are not limited to the current toll-free number) should be available at all sites of tobacco sales. (MSS Amended Sub Res 36, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>96</td>
<td>505.010MSS</td>
<td>Smoke-free Workplace: AMA-MSS will ask the AMA to: (a) draft model state legislation to eliminate smoking in public places and businesses, possibly modeled on existing laws in California and Delaware; and (b) encourage individual medical students, residents, and physicians – as well as medical schools, hospitals, clinics, and physician practices – to endorse, support, and lobby for local and state legislation to eliminate smoking in public places and businesses as a “workers right” issue. (MSS Res 1, I-02) (AMA Sub Res 923, I-02 Adopted [H-505.966]) (Amended: MSS Rep C, I-07) (Modified and Reaffirmed: MSS Rep C, I-12)</td>
<td>Modify and Retain- AMA Policy H-505.966 has been updated. This policy has notable historic success, but should reflect current laws on smoking in the workplace.</td>
</tr>
<tr>
<td>97</td>
<td>515.005MSS</td>
<td>Protection of the Privacy of Sexual Assault Victims: AMA-MSS will ask the AMA to condemn the publication or broadcast of sexual assault victims’ names, addresses, or likenesses without the explicit permission of the victim. (MSS Sub Res 21, I-97) (AMA Res 406, A-98 Adopted [H-515.967]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>#</td>
<td>MSS Number</td>
<td>Description</td>
<td>Retain Status</td>
</tr>
<tr>
<td>----</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>98</td>
<td>515.008MSS</td>
<td>The Identification and Protection of Human Trafficking Victims: AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking. (MSS Res 19, A-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>99</td>
<td>530.012MSS</td>
<td>Product Endorsements: AMA-MSS supports policy whereby the AMA shall not endorse any products or services produced by other companies and marketed to consumers unless approved by the Board of Trustees, with no endorsements being made on an exclusive basis. (MSS Sub Res 5, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</td>
<td>Retain- still relevant</td>
</tr>
<tr>
<td>#</td>
<td>Item</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------</td>
<td>-------------</td>
<td></td>
</tr>
</tbody>
</table>
| 100 | 630.072MSS | Policy-Making Procedures: The MSS Governing Council will create a task force to evaluate the pilot approach proposed for I-12, and research the policy-making procedures of the MSS Assembly, with clarification to the Internal Operating Procedures as appropriate, and recommend a process for future implementation to ensure proper and efficient consideration of the items of business of the MSS Assembly. (MSS GC Rep A, I,12)  
**Sunset**: Specific to A-12, Further study completed and changes implemented in subsequent years |
| 101 | 640.014MSS | Regional Representation on MSS Committees: The AMA-MSS Governing Council will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees. (MSS Amended Sub Res 21, I-07) (GC Rep C, A-10 Filed [640.016MSS]) (Modified and Reaffirmed: MSS GC Rep C, I-12)  
Retain- still relevant |
Retain- still relevant |
| 103 | 645.019MSS | European Medical Student Association (EMSA) - Official Observer: The AMA-MSS will invite the European Medical Students Association to send a non-voting Official Observer to all meetings of the AMA-MSS Assembly. (MSS Rep E, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)  
Retain- still relevant |
<p>| 104 | 655.018MSS | Membership Retention into Residency: AMA-MSS will continue to explore ways to increase awareness of the Medical Student and Resident Fellow Sections in order to increase membership retention during the transition to residency. (MSS COLRP Rep A, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) | Retain- still relevant |
| 105 | 655.025MSS | Increasing the Efficiency of Student Membership Application Processing: AMA-MSS encourages the AMA to continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members. (MSS Sub Res 4, A-01) (Amended MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report C, I-12) | Retain- still relevant |
| 106 | 655.028MSS | The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters: AMA-MSS strongly encourages every medical school to designate a permanent position within their chapter to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the chapter provide the individual’s name and current mailing address to the AMA Medical Student Section Outreach Program prior to each Annual Meeting. (MSS Res 1, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) | Retain- still relevant |</p>
<table>
<thead>
<tr>
<th></th>
<th>660.017MSS</th>
<th><strong>Campaign Reform: AMA-MSS encourages all members to recognize the commitments of the candidates at the Interim and Annual meetings and use prudent judgment when inviting them to address group meetings and furthermore strive for fair and equal access to all candidates and all sections, states, and societies. (MSS Amended Sub Res 3, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)</strong></th>
<th>Retain- still relevant</th>
</tr>
</thead>
</table>

**Appendix 2 – Recommendations for Policy Consolidation: 305.XXXMSS Finances of Application to Medical School and Residency**
Medical School Admission Policies: AMA-MSS will ask the AMA to: (1) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (2) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and of the sources of financial aid available; and (3) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools. (AMA Res 142, A-81 Referred) (BOT Amended Rep JJ, I-81 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Studying Medical School Secondary Application Fees: AMA-MSS will study the criteria used by allopathic and osteopathic medical schools to set medical school secondary application fees, how secondary application fees are allocated and used, and the effects of secondary application fees on the application characteristics and choices of medical school applicants, with report back at I-10. (MSS Sub Res 6, I-09) (Reaffirmed: MSS GC Rep A, I- 14)

Reducing the Financial and Educational Costs of Residency Interviews: That our AMA consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews. And that the AMA-MSS consider the following strategies to address the high financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:

1. AMA-MSS supports the incorporation of admissions practices that objectively evaluate applicants' behavioral competencies into future AMA medical education funding initiatives.
2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and of the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.
3. That our AMA consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing
cost of interviewing for residency: (a) considering producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMAMSS webpage, (b) creating and/or promote specific websites related to med student travel, and (c) providing or recommending an online forum where students can accommodate other medical students who are interviewing in their area. (Sub Res 2, A-12) (GC Rep A, A-14)

305.078 Incorporating Behavioral Competencies into Admissions for Schools Receiving AMA Medical Education Grants: AMA-MSS supports the incorporation of admissions practices that objectively evaluate applicants’ behavioral competencies into future AMA medical education funding initiatives. (MSS Res 4, A-13)

on the AMA-MSS webpage, (d) creating and/or promote specific websites related to med student travel, and (e) providing or recommending an online forum where students can accommodate other medical students who are interviewing in their area.
Medical School Tuition

**305.006 Preservation of Manageable Tuition Rates Through Medical School Financial Assistance:** AMA-MSS will ask the AMA to encourage state medical societies to support the introduction of legislation that would increase state subsidies to public and private medical schools within their states. (AMA Res 149, A-81, Referred) (BOT Amended Rep JJ, I-81, Adopted in lieu of Res 149 [H-305.995]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**305.010 Medical School Tuition:** AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class. (MSS Rep H, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**305.037 Medical School Tuition:** The AMA-MSS Governing Council will continue to work with AMA staff to ensure student concerns on indebtedness and medical school tuition are addressed in all health system reform legislation. (MSS Sub Res 27, I-93) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**305.046 Mid-Year and Retroactive Medical School Tuition Increases:** AMA-MSS will ask the AMA to: (1) work with the AAMC to discourage assessment of mid-year and retroactive increases in medical school tuition and fees; and (2) encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases including but not limited to state subsidies to public and private medical schools within their state.

**305.xxx MSS Medical School Tuition:** The AMA-MSS supports the following principles regarding medical school tuition:

1. That the AMA-MSS joins the AMA in its opposition of mid-year and retroactive medical school tuition or fee increases and encourages collaborations in this opposition, including the AAMC.
2. That the AMA-MSS will ask the AMA to study, in collaboration with state, specialty, and other interested organizations, the case precedent, timing, risks, and other considerations in filing an application for injunctive relief to block retroactive or mid-year tuition increase.
3. That the AMA-MSS will encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases including but not limited to state subsidies to public and private medical schools within their state.
4. That the AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class.
5. That the AMA-MSS joins the AMA in its opposition of medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity.
6. That the AMA-MSS will ask the AMA to discourage U.S. medical schools from requiring accepted international students to...

| 305.051 | Injunctive Relief Against Medical School Tuition Increases After the Start of the Academic Year: AMA-MSS will ask the AMA to study, in collaboration with state, specialty, and other interested organizations, the case precedent, timing, risks, and other considerations in filing an application for injunctive relief to block retroactive or mid-year tuition increases, with report back at I-03. (MSS Res 4, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) |
| 305.057 | Legal Injunction on Medical School Tuition Increases: AMA-MSS supports and will ask the AMA to support the use of legal injunctions to block mid-year and retroactive medical school tuition or fee increases. (MSS Res Late 1, I-04) (AMA Res 833, I-04 Referred) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) |
| 305.064 | Financial Assistance for International Students Enrolled in U.S. Medical Schools: AMAMSS will ask the AMA to discourage U.S. medical schools from requiring accepted international students to pay more than a single term’s tuition at each billing period, in the same manner as the rest of the U.S. citizens and permanent U.S. residents within the student body. (MSS Res 8, I-09) (AMA Res 312, A-10 Referred) (Reaffirmed: MSS GC Rep A, I-14) |
| 305.066 | Opposition to Tuition Taxes: AMA-MSS opposes, and will ask the AMA to oppose, medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity. (MSS Res 3, A-10) (AMA Amended Res 905, I-10 Adopted [H- 305.934]) (Reaffirmed, MSS |
### Federal Loans

**305.007 Federal Guidelines for Loan Parameters:** AMA-MSS supports the following principles and will ask the AMA to support legislation to enact these principles:
1. Government sponsored in-school loan interest subsidies should be maintained.
2. Annual and aggregate loan limits should be increased to reflect the true cost of medical education at the student applicant's medical school.
3. The Parent Loan Program should be expanded so that parents and spouses of medical students with financial need can borrow at less than market rates.
4. Medical students attending school twelve months per year should not be required to provide summer earnings allowances as partial fulfillment of their loan requirements.

(AMA Res 150, A-81 Referred) (BOT Amended Rep JJ, I-81, Adopted in lieu of Res 150)  
(Reaffirmed: MSS COLRP Rep B, I-95)  
(Reaffirmed: MSS Rep B, I-00)  
(Reaffirmed: MSS GC Rep F, I-10)  
(Reaffirmed: MSS GC Rep D, I-15)

**305.025 Taxation of Federal Student Aid:** AMA-MSS will ask the AMA to oppose legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA).

(AMA Res 210, I-91 Adopted [H-305.962])  
(Reaffirmed: MSS Rep B, I-00)  
(Reaffirmed: MSS Rep E, I-05)  
(Reaffirmed: MSS GC Rep F, I-10)  
(Reaffirmed: MSS GC Rep D, I-15)

**305.052 Reduction in Student Loan Interest Rates:** AMA-MSS supports actively lobbying for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.

(2) AMA-MSS will specifically encourage members to write letters to senators and representatives, especially

**305.xxx MSS Medical Students Federal Loans:**

The AMA-MSS supports the following principles regarding federal loans and taxation:

1. The AMA-MSS supports actively lobbying for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. The AMA-MSS supports and will ask the AMA to Support government sponsored in-school loan interest subsidies should be maintained.
3. The AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate.
4. The AMA-MSS will ask the AMA to lobby for passage of legislation that would (1) eliminate the cap on the student loan interest deduction (2) increase the income limits for taking the interest deduction. (3) an increase to annual and aggregate loan limits to better reflect the true cost of medical education at the student applicant’s medical school.
5. The AMA-MSS asks the AMA to support legislation that does not require medical students attending school full-time twelve months per year to provide summer earnings allowances as partial fulfillment of their loan requirements.
6. The AMA-MSS will ask the AMA to lobby
those on the appropriate specific subcommittees, to support the revisitation of the issue of how interest rates on student loans are determined and will provide a sample letter of support for this cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.

(MSS Late Res 1, A-03) (AMA Amended Res 316, A-03 Adopted [D-305.984]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

305.053 Expanding and Strengthening AMA Advocacy on Medical Student Debt: (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. (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),

305.076 Collaborative Effort to Reduce Federal Loan Interest Rates: AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate. (MSS Res 10, I-12) (Amended AMA Res 302, A-13 Adopted [D-305.984])

for passage of legislation that would make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001.

7. The AMA-MSS will ask the AMA to oppose legislation that would allow medical school scholarships or fellowships to be subject to federal income or social security taxes (FICA)

8. The AMA-MSS will encourage members to write letters to senators and representatives, especially those on the appropriate specific subcommittees, to support the revisitation of the issue of how interest rates on student loans are determined and will provide a sample letter of support for this cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.

Dependent and Spousal Care:
305.007 Federal Guidelines for Loan Parameters: AMA-MSS supports the following principles and will ask the AMA to support legislation to enact these principles: (1) Government sponsored in-school loan interest subsidies should be maintained (REDUNDANT); (2) Annual and aggregate loan limits should be increased to reflect the true cost of medical education at the student applicant’s medical school; (3) The Parent Loan Program should be expanded so that parents and spouses of medical students with financial need can borrow at less than market rates; (4) Medical students attending school twelve months per year should not be required to provide summer earnings allowances as partial fulfillment of their loan requirements.

305.041 Recognizing Dependent Care Expenses in Determining Graduate Medical Education Financial Aid: AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, health care, and dependent care for all dependents. (MSS Amended Sub Res 9, A-97) (AMA Amended Res 205, I-97 Adopted [305.941]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

305.049: Recognizing Dependent Care Expenses In Determining Medical Education Financial Aid: (1) AMA-MSS will ask the AMA to: (a) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense in medical student financial aid budgets 3. That the AMA-MSS ask its Council on Medical Education, Academic Leadership Section, and Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses.

305.xxx MSS Medical Student Dependent and Spousal Care: The AMA-MSS supports the following principles regarding the care of medical school students’ spouses and dependents:

1. That the AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, healthcare, and dependent care for all dependents.

2. That the AMA-MSS supports and will ask the AMA to work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent, spousal and same-sex spousal equivalent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense in medical student financial aid budgets.

3. That the AMA-MSS ask its Council on Medical Education, Academic Leadership Section, and Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses.

4. The AMA-MSS supports and will ask the AMA to (1) support the Parent Loan Program and its expansion so that parents and spouses of medical students with financial need can borrow at less than market rates.
"cost of attendance" and as an educational expense for the purposes of student budgets and financial aid; and (c) ask its Council on Medical Education, Section on Medical Schools Academic Leadership Section, and Women’s Physician Congress Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses; (2) AMA-MSS supports the inclusion of dependent care, health insurance, and living expenses in medical student financial aid budgets. (MSS Res 12, A-02) (AMA Amended Res 301, A-03 Adopted [D-305.986]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

305.050: Recognizing Spousal Care Expenses in Determining Medical Education Financial Aid: AMA-MSS supports the inclusion of spousal health insurance in medical student financial aid budgets and encourages medical schools to include spousal and same-sex spousal equivalent health insurance as part of the “cost of attendance” and as an educational expense for the purposes of student budgets and financial aid. (MSS Res 1, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

**Voluntary Service Payback and Loan Repayment Programs:**

<table>
<thead>
<tr>
<th>305.008 Voluntary Service-Payback Programs: AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs, and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas. (AMA Res 147, A-81 Referred) (BOT Rep BB, I-81 Adopted in Lieu of Res 147) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Res 3, I-05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>305.xxx Voluntary Service-Payback and Loan Repayment Programs: The AMA supports the following principles regarding voluntary service-payback and loan repayment programs: 1. That the AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs, and support the development of other voluntary programs that finance</td>
</tr>
</tbody>
</table>
### Access to Financial Aid:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| **305.079** | Inclusion of Preventive Medicine Physicians in the National Health Service Corps Loan Repayment Program: That our AMA advocate for the inclusion of physicians trained in Preventive Medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.  
(MSS Res 5, A-14) |
| **305.001** | Medical Student Loan Program: AMA-MSS will ask the AMA to: (1) ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a choice of funding to students; and (2) recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite term.  
(AMA Res 81, I-80 Adopted [H-305.996])  
(Reaffirmed: MSS COLRP Rep B, I-95)  
(Reaffirmed: MSS Rep B, I-00)  
(Reaffirmed: MSS Rep E, I-05)  
(Reaffirmed: MSS GC Rep F, I-10)  
(Reaffirmed: MSS GC Rep D, I-15)  
(Reaffirmed: MSS GC Rep D, I-15) |
| **305.009** | Defaulted Government Loans: AMA-MSS will ask the AMA to: (1) urge increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and (2) encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.  
(AMA Res 79, A-82 Adopted [H-305.994])  
(Reaffirmed: MSS COLRP Rep B, I-95)  
(Reaffirmed: MSS Rep B, I-00)  
(Reaffirmed: MSS Rep F, I-10)  
(Reaffirmed: MSS GC Rep D, I-15)  
(Reaffirmed: MSS GC Rep D, I-15) |
| **305.xxx** | Increasing availability and access to financial aid:  
The AMA-MSS supports the following principles regarding access to student loans and availability of financial aid and scholarship monies:  
1. That the AMA-MSS will ask the AMA to ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a choice of funding to students  
2. That the AMA-MSS will ask the AMA to recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite term  
3. That the AMA-MSS will ask the AMA to work with state medical societies, associated foundations and medical schools to ensure that information about all offered scholarships is readily available online  
4. That The AMA-MSS will ask the AMA to societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary-care |

305.053 Expanding and Strengthening AMA Advocacy on Medical Student Debt: (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. (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)

305.055 Improving and Expanding State Medical Society Scholarship Programs: (1) AMA-MSS will and will ask the AMA to: (a) work with the state medical societies and their associated foundations along with medical schools to ensure that information about all scholarships they offer is readily available online; (b) strongly urge each state medical society to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body; (c) collect and propagate model bylaws changes from state foundations that have added medical students to their Boards of Directors; (2) AMA-MSS will ask the AMA to: (a) urge, via its component state medical societies, all state foundations to consider specialties.

5. That the AMA-MSS will ask the AMA to urge each state medical society strongly to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body in addition to collecting and propagating bylaw changes from state societies that have added a medical student vote to their Board of Directors

6. That the AMA-MSS will ask the AMA to urge, via its component state medical societies, all state foundations to consider converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversion

7. That the AMA-MSS will ask the AMA to request that the state foundations and the AMA Foundation to encourage donors to pool their funds with others to endow large scholarships;

8. That the AMA-MSS will ask the AMA to request that the AMA Foundation to work with state medical societies and their foundations to (1) make scholarship programs direct-application at the medical school level (2) ensure that scholarship funds are disbursed directly to the student, not to the medical school

9. That the AMA-MSS will ask the AMA to request that the AMA Foundation compile and distribute to the state foundations a list of fundraising “best practices” that have been shown to be effective in raising funds for medical scholarships
converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversion; (b) ask the state foundations and the AMA Foundation to encourage donors to pool their funds with others to endow large scholarships; (c) ask the AMA Foundation to work with the state medical societies and their foundations to ensure that scholarship funds are disbursed directly to the student, not to the medical school; (d) ask the AMA Foundation to work with state medical societies and their foundations to make scholarship programs direct-application at the medical school level; and (e) ask the AMA Foundation to compile and distribute to the state foundations a list of fundraising “best practices” that have been shown to be effective in raising funds for medical scholarships. (MSS Res 4, I-04) (AMA Res 616 and 617, I-04 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

Debt Management Education for Students:


305.xxx Medical Student Debt Management Education:
The AMA-MSS supports the following principles regarding financial management and debt education of medical students: 1. That the AMA-MSS will ask the AMA to encourage medical school financial aid offices to educate medical students in medical debt management and provide financial and tax counseling 2. That the AMA-MSS will ask the AMA to assist medical school financial aid offices in implementing debt management, financial, and tax counseling
MSS will ask the AMA to: (1) urge increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and (2) encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.

(AMA Res 79, A-82 Adopted [H-305.994])
(Reaffirmed: MSS COLRP Rep B, I-95)

305.073 Transparency in Medical Student Financial Aid Reporting: AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants by encouraging medical colleges to provide additional data to students and applicants including but not limited to: (1) average debt incurred in medical school for graduating students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles (2) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution. (MSS Res 1, A-12)

Student Loan Forgiveness:

305.003 Loan Forgiveness Program: AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as one

305.xxx Medical Student Loan Forgiveness:
The AMA-MSS supports the following

305.075 Retaining Public Service Loan Forgiveness: AMA-MSS will ask the AMA to (1) oppose the reduction of medical student and physician benefits or the creation of more stringent requirements for qualification under Public Service Loan Forgiveness; and (2) support the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness. (MSS Res 7, I-12) (Amended AMA Res 304, A-13 Adopted)

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

principles regarding student loan forgiveness:
1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students..
2. That that AMA-MSS will ask the AMA to oppose the reduction and support the expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness
3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including but not limited to the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency

The policies not included in the consolidation of 305.XXXMSS Finances of Application to Medical School and Residency include: 305.036MSS, 305.039MSS, 305.043MSS, 305.060MSS, 305.062MSS, and 305.077MSS
INTRODUCTION

At its 2016 Interim meeting, the AMA-MSS Assembly referred for study the second resolve clause of MSS Resolution 5, “Increasing Access to Healthcare Insurance for Refugee Populations,” which states the following:

RESOLVE, That our AMA support federal and state government agencies to facilitate enrollment or re-enrollment of refugees into Medicaid healthcare insurance plans following the end of their Refugee Medical Assistance coverage or initial Medicaid coverage.

Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Global and Public Health (CGPH). Your CGPH performed an analysis of pertinent policies on healthcare access for refugee populations so that the MSS could account for the specific Refugee Medical Assistance and Medicaid considerations at the state and federal level in regards to enrollment and re-enrollment of newly arrived or resident refugees.

This report begins with an historical overview of refugee health insurance plans at the state and federal level. It then examines pertinent implications of MSS Resolution 5 I-16. Your CGPH feels that amendment to MSS Resolution 5 I-16 will best preserve the intended goals of this resolution by clarifying the language and spirit of the second resolve clause, as reflected in the Recommendations portion of this report.
BACKGROUND

i. Characteristics of Refugee Populations and Access to US Healthcare

A refugee in the United States (US) is legally defined by section 101(a)(42) of the Immigration and Nationality Act. The US President, along with guidance from Congress, sets a limit for the number of refugees from each geographic region who can resettle in the US during the given fiscal year. Refugee status is determined by the US Citizen and Immigration Services (a division of the US Dept of Homeland Security) or the Office of Refugee Resettlement (ORR, a division of the US Dept of Health and Human Services). All refugees are admitted and screened by the US Refugee Processing Center (RPC), a division of the US Department of State.

In broad terms, a refugee is a person with the following variables: 1) located outside of the United States; 2) is of special humanitarian concern to the United States; 3) demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group; 4) is not firmly resettled in another country; and 5) is admissible to the United States.

The total number of refugees allowed admission to the US varies by region and year, according to priorities set by the federal executive and legislative branches. Between fiscal years 2005 and 2015, 675,982 persons fitting the definition of “refugee” immigrated to the United States, with a total of 69,933 resettling in 48 of 50 states during Fiscal Year 2015. During Fiscal Year 2016, 84,995 refugees were admitted to the US.

Most refugee admissions in a given year come from just a few countries. Over the past five years (2012-2017), most refugees originated in Burma (75,790), Iraq (73,976), Bhutan (44,230), Somalia (39,397), and the Democratic Republic of the Congo (33,212).

ii. Importance of Refugee Access to Healthcare & Health Insurance

Refugees encounter a number of unique medical challenges that require access to healthcare. The ORR found that 38.0% of refugees resettled over the past five years are unable to participate in the labor force due to poor health or disability, making enrollment and re-enrollment in health insurance programs critical.

In a sample of adult refugees who arrived between 2006 and 2010, more than half were diagnosed or treated for at least one chronic NCD, while over 20% suffered from two or more. The most prevalent NCDs were behavioral health problems (15.0%), hypertension (13.3%), and dyslipidemia (9.4%). Additionally, risk factors for chronic disease such as being overweight or using tobacco have been found to be relatively high, 31.3% and 28.9% respectively, among newly arrived refugee populations. Because the healthcare system in many refugees’ countries of origin are impacted by natural disasters, political unrest, insecurity, and physical violence, individuals with such medical conditions may not have received adequate care prior to arrival in the US. Increased health insurance coverage has shown to increase health care utilization, which would benefit refugees who suffer from these NCDs and other chronic conditions.

Events prior to a refugee’s resettlement in the US also contribute to refugee health concerns. The burden of adverse mental health conditions throughout this population is significantly higher than non-refugee populations. In some studies of refugee populations in Europe and the US, rates of
emotional distress, anxiety, and depression were found to be as high as 50% and between 25% and 31% of the individuals sampled were found to be at risk for post-traumatic stress disorder. Additionally, numerous studies have shown adverse childhood experiences to increase risk for mental health conditions and age-related disease in adulthood, increasing the need for refugee populations who have experienced traumatic events to access comprehensive and continuous medical treatment.

iii. Health Insurance Enrollment for New-Arrival Refugee Populations

Through the Refugee Act of 1980, the US government indicated the relevance of providing medical and legal assistance to refugees in the US. However, this legislation has not wholly addressed the logistical challenges in connecting refugees to necessary services. The ORR Annual Survey of Refugees found that among 2015 cohort of new refugees, only 67.7% reported utilizing Medicaid or RMA over the past year, whereas 92.5% received nutrition assistance through Supplemental Nutrition Assistance Program, which can indicate that more people likely qualified for Medicaid.

Refugees are “qualified non-citizens”. This means they may receive health insurance through different avenues upon arrival in the US and are typically not subject to the five-year waiting period for Medicaid or CHIP. Most refugees are eligible for enrollment in the Healthcare Marketplace though potential changes to the Affordable Care Act suggested by the sitting Congress makes this route to enrollment particularly vulnerable.

Because Medicaid eligibility is ultimately decided by the state, some refugees do not qualify for Medicaid or CHIP. The ORR offers benefits and services for those who are ineligible for Medicaid and other assistance programs through a federal program called Refugee Medical Assistance (RMA), which provides health insurance for eight months.

iv. Health Insurance Re-enrollment for Settled Refugee Populations

Individuals and families previously eligible for health insurance through Medicaid and CHIP programs during the first eight months may be able to continue to utilize those options, though potential barriers to access may limit re-enrollment, particularly in those states that do not participate in Medicaid expansion or have insurance premiums higher than the national average. Refugees may also be able to qualify for tax credits towards purchasing health insurance from the Health Insurance Exchanges established by the Affordable Care Act if their income falls below 400% of the Federal Poverty Line (FPL).

Approximately 67.7% of refugees resettled in 2015 reported receiving insurance coverage through either RMA or Medicaid during the first year after arrival. However, rates of public health insurance utilization fall precipitously following the first year after arrival. Among refugees who were resettled in 2013 and 2011, only 48.6% and 33.5% respectively reported receiving coverage through Medicaid in 2015. Notably, health insurance coverage rates through an employer-offered plans notably rose from 4.3% to 20.6% between the 2015 and 2011 cohorts, however this does not account for the entirety of the drastic drop of Medicaid-insured refugees. This reduction in public health insurance enrollment is likely, then, to be related to a multitude of factors including trouble with re-enrollment, reduced eligibility, or increased financial dependence.

While only 4.4% of refugees who arrived in 2015 reported no insurance for the preceding twelve months, 14.2% of the 2011 cohort reported going without health insurance coverage for the entire...
v. Barriers to Enrollment and Re-Enrollment

In obtaining and maintaining healthcare, refugees often experience many barriers that hinder access to care. Primarily, insurance coverage and cost for obtaining medical care are two of the most commonly reported challenges among refugees. Refugees consistently report difficulty in navigating public insurance enrollment, lacking employer-offered healthcare, and decreased ability to afford insurance fees and prescription costs.

Likewise, language plays an important role and is often seen as the most prevalent barrier to accessing insurance and care. Among refugee arrivals in 2015, 85.9% reported not speaking English or speaking at a limited capacity upon arrival. This rate only decreased to 66.8% one-year post resettlement.

While individuals with low English proficiency (LEP) makeup 8.6% of the US population, this group is uninsured at much higher rates, accounting for 21.7% of the uninsured population. Furthermore, numerous reports show patients with LEP do not have appropriate interpretation services during medical appointments, thus leading to decreased understanding of their health status and increased risk for complications and adverse outcomes. However, it has been shown that when individuals with LEP are assisted with insurance enrollment and interpretation services throughout their medical care, they show consistent healthcare enrollment long term and reduced frequency of coverage gaps. These individuals are also more likely to utilize primary and preventative care services and exhibited a reduced likelihood of seeking medical care through emergency services, therefore resulting in lower healthcare costs.

vi. Financial Considerations

Over the past ten years (2007-2016), a total of 665,940 refugees have been resettled in the United States- an average of 66,594 each year. The average expenses for each adult receiving Medicaid benefits in 2014 was $5,736. This average expense is also closely comparable to the RMA cost per refugee which is $5,480. Both of averages fall below the national average for medical expenditures per individual at $8,034.

The ORR and Census Bureau report that between 17,500 and 35,000 resettled refugees who arrived within the last three lack health insurance. The estimated cost to extend Medicaid to uninsured refugees for one year past the initial eight-month period currently covered by RMA would be on average $100 million a year.

AMA’s AND AMA-MSS POLICIES ON REFUGEES AND ACCESS TO CARE

1. AMA-MSS

Your CGPH felt that the support offered by MSS policy 250.028MSS, which calls for refugee insurance coverage support by “state, local and community programs,” is relevant to refugee healthcare. However it does not address the unique barriers that exist for enrollment and re-enrollment of refugee populations. As determined, enrollment and re-enrollment are key issues in refugee healthcare access.

This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder (www.ama-assn.org/go/policyfinder) for official policy of the Association.
2. **AMA**

In 2017, the AMA House of Delegates restructured its policy on insurance coverage for refugees. These changes are reflected in the policies put forth by the AMA.

**Increasing Access to Healthcare Insurance for Refugee Populations H-350.956**

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.

**Addressing Immigrant Health Disparities H-350.957**

1. Our AMA recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (1) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (2) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (3) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

**DISCUSSION**

The second resolve clause of MSS Resolution 05-I-16 asks for the AMA to support enrollment and re-enrollment of refugees in the programs for which they are eligible. Refugees have unique healthcare needs and continued barriers to insurance coverage, despite existing state and federal policy.

Many states utilize Medicaid resources to cover refugees and RMA provides an additional safeguard for the population that cannot obtain state coverage. Theoretically, close to 100% of the refugee population should obtain initial healthcare enrollment. However, per the ORR 2015 Annual Survey of Refugees, 67.7% utilized resources to obtain initial health insurance and 33.3% did not. The latter cohort is of particular concern as the lack of coverage may have been caused by the aforementioned barriers. The absence of medical coverage for the refugee population has shown to subsequently rise after the initial allotted time of coverage is passed. It can be postulated that the presence of barriers contributes to the decrease in re-enrollment and ultimately the rising number of uninsured persons. These challenges are present in the face of individuals who have great medical needs and require long term management.

Given the local and national systems already in place, it is prudent that AMA voices support for the utilization of resources by the refugee population. AMA’s affirmation can strengthen the abilities of the state and federal agencies to provide eligible persons, who are otherwise not receiving pre-allocated resources, with coverage. In addressing barriers, particularly related to language and culture, issues pertaining to initial enrollment and maintenance of enrollment may
be better undertaken, as alluded to in AMA policy H-350.956.

CONCLUSION

Your AMA has supported numerous policies supporting the overall health for refugee populations, including policy H-350.956 put forward at A-17 as a result of the first resolve of MSS Resolution 5-I-16, and has therefore previously acknowledged this population’s unique barriers to healthcare and insurance access.

Accordingly, your CGPH believes that addressing support of agencies that enroll and re-enroll refugee populations is crucial to protecting individual patients and the public health. CGPH believes this is already addressed in H-350.956 and MSS Resolution 5-I-16 is therefore redundant in AMA policy. Additionally, your CGPH believes that AMA-MSS policy 250.028MSS does not adequately represent AMA-MSS’s stance on enrollment and reenrollment of refugee healthcare. CGPH believes that the spirit of the resolve clause is appropriate, yet requires clarification. Your CGPH feels that the specific language of Resolution 5 should be amended as such.

RECOMMENDATIONS

1. That the AMA-MSS amend the second resolve clause of Resolution 5 by addition and deletion to read as follows:

   RESOLVED, That our AMA-AMA-MSS support the efforts of federal and state government agencies to facilitate enrollment or reenrollment of eligible refugees into Medicaid, CHIP healthcare or Refugee Assistance insurance plans, and to facilitate re-enrollment in appropriate plans for refugees for whom Medicaid or RMA coverage has lapsed following the end of their Refugee Medical Assistance coverage or initial Medicaid coverage.

   A clean version of your CGPH’s proposed amendments follows.

   RESOLVED, That our AMA-AMA-MSS support the efforts of federal and state government agencies to facilitate enrollment or re-enrollment of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans.


3. The remainder of this report be filed.

ACKNOWLEDGEMENTS

This report was assembled by members of the 2017-18 AMA-MSS Committee on Global and Public Health (Stephen Crabbe, Rohit Abraham, Usman Hasnie, Sohayla Rostami, and...
REFERENCES
1. Immigration and Nationality Act.
20. Gonzales, Gilbert. State estimates of limited english proficiency (LEP) by health insurance


INTRODUCTION

At the 2016 Medical Student Section (MSS) Interim Meeting, Paul Donegan of Rowan University school of Osteopathic Medicine and Usman Hasnie of University of Missouri-Kansas City School of Medicine submitted MSS Resolution 35 “Support for Researching Non-Judicial Enforcement of Medicaid Rate Challenges Under 42 U.S.C Section 1396(a)(30)(A) in Wake of Armstrong v. Exceptional Child Center, Inc.,” which was amended by your MSS Assembly and referred for study. The amended Resolve clauses read as follows:

RESOLVED, That our AMA-MSS raise awareness about the rulemaking process of the Administrative Procedure Act (APA) to encourage health care provider participation in the notice and comment period for regulations proposed by federal agencies that concern Medicaid rate setting; and be it further

RESOLVED, That our AMA-MSS support a study that reviews the effect of changes to Medicaid payment methodologies on beneficiary access in light of providers and beneficiaries no longer having an implied right of action under the Supremacy Clause to enforce the Equal Access Provision [Section 30(A)] of the Medicaid Act; and be it further

RESOLVED, That our AMA-MSS support a study that reviews network adequacy standards for Medicaid managed care plans in light of providers and beneficiaries no longer having an implied right of action under the Supremacy Clause to enforce the Equal Access Provision [Section 30(A)] of the Medicaid Act; and be it further
RESOLVED, That our AMA-MSS support a study that reviews whether a more dominant non-judicial process for the enforcement of the Equal Access Provision [Section 30 (A)] of the Medicaid Act minimizes the need for providers and beneficiaries to seek judicial enforcement of the Equal Access Provision.

Accordingly, your MSS Governing Council (GC) assigned this report to your MSS Committee on Economics and Quality in Medicine (CEQM).

BACKGROUND


Under the provisions of 42 U.S.C. §1396a(a)(30)(A) of the Social Security Act, Medicaid programs, which are established by individual states but receive both state and federal funding, must provide “payments… sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”1. Although this provision, known as the Equal Access Provision, was formally codified as statute by Congress in 19892, effective and consistent enforcement of sufficiency in access to care (“access”) remains out of reach. The National Academy of Medicine defines access as the “timely use of personal health services to achieve the best possible outcomes”3 however this definition provides little clarity on how to apply the Equal Access Provision.

II. Armstrong v. Exceptional Child Center, Inc.

This predicament was exacerbated in early 2015 by the United States Supreme Court’s holding in Armstrong v. Exceptional Child Center, Inc. (Armstrong).4 In Armstrong, the primary question was the extent private entities, such as doctors and hospitals, could seek judicial injunctive relief from state laws or regulations reducing or modifying payments to providers in a manner that results in a violation of the requirement for sufficient access laid out in §30(A). The Court held 5-4 that, in such cases, private entities have no standing to petition for the enforcement of federal law under the Supremacy clause of Article VI of the US Constitution, which states that federal law is supreme to incompatible state law.

Armstrong effectively eliminated the ability for providers and beneficiaries to pursue judicial enforcement on the basis of the Supremacy Clause. Justice Scalia, in writing the majority opinion, found that healthcare providers could not enforce the Medicaid payment provisions because Congress did not explicitly intend for them to do so. He notes that the “sole remedy” provided by Congress in 1989 Medicaid updates is for Secretary of Health and Human Services to enforce their rules is through the termination of federal funding to all or parts of the state Medicaid program. Furthermore, this opinion determined that the “[e]xpression of one method of enforcement suggests that Congress intended to preclude others,” leaving Centers for Medicare and Medicaid Services (CMS) with limited options to enforce its rules.4
III. Centers for Medicare and Medicaid Services Role and Response

Improving access to care has been a priority for policymakers at the Centers for Medicare and Medicaid Services (CMS), but also has also proven challenging.

In attempting to develop a clear and rigorous set of expectations for the states to address increasingly apparent issues with access, CMS encountered particular difficulty in determining how best to actually measure it. Meanwhile, in a vexing fiscal climate, provider reimbursement reductions continued to create problems with access.

When faced with challenges against states that are failing to comply with the equal access provisions of Medicaid and underpaying healthcare providers, CMS has had to decide whether those infractions are serious enough to merit the complete suspension of the state’s Medicaid program. This is hardly a balanced response, interrupting reimbursements to providers and disrupting access to care for patients. As many rate challenges would likely not merit this kind of disciplinary action for enforcement, the concern after Armstrong is whether CMS now has the ability to enforce any of its Medicaid regulations at all. Past HHS officials made a note to acknowledge how important it was for providers to seek judicial enforcement of Medicaid provisions. Its amicus brief emphasized that “[e]very aspect of [HHS’s] administration of the Medicaid program - from its regulations to its annual budget - is premised on the understanding that private parties will shoulder much of the enforcement burden. CMS lacks the logistical and financial resources necessary to be the exclusive enforcer of the equal access mandate, and it is highly unlikely to receive the necessary resources in the future.”

IV. AMA Policy and CMS Report 2-A-16

AMA Policy D-290.976 established at the 2015 Annual Meeting asked the AMA to, among other things, “study the adequacy of provider payments for those services rendered to those in the Medicaid expansion population”

The results of the study were documented in the Council on Medical Service Report 2 presented at the 2016 House of Delegates Annual Meeting. The report had a series of recommendations that resulted in AMA Policies H-290.966-Medicaid Expansion Options and Alternatives, H-165.855-Medical Care for Patients with Low Incomes, and H-290.965-Affordable Care Act Medicaid Expansion. Of particular importance is AMA Policy H-290.965, which states the following:

1. Our AMA encourages state medical associations to participate in the development of their state’s Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector
General's recommendations to improve access to care for Medicaid beneficiaries.

4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.

5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.

6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.

7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.

8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.

9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.

10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.

11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.

13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

DISCUSSION

I. First Resolve

The first Resolve asks the AMA-MSS to raise awareness around and increase individual provider participation in providing public commentary toward regulatory changes related to Medicaid rate setting. While physicians and other healthcare providers can provide a crucial perspective in any Medicaid regulatory changes, we believe a campaign to raise awareness is unnecessary. This would require the AMA-MSS to undertake a large advertising or social media campaign, which falls outside the scope of activities of the AMA-MSS. If Res 35-I-16 was amended to be AMA policy rather than AMA-MSS policy, H-290.965 already covers this scope. There is no evidence to suggest that these efforts by the AMA are inadequate; therefore, we recommend that the first Resolve not be adopted.

II. Second Resolve

The second Resolve asks the AMA-MSS to study whether changes to the Medicaid payment environment will affect access to health care for Medicaid beneficiaries. While it is plausible that changes to Medicaid payment methodologies may affect access to healthcare providers, CMS requires that states demonstrate payments are sufficient to ensure adequate access to health care.
care in compliance with section 1902(a)(30)(A) of the Social Security Act. Furthermore, H-290.965 already encourages CMS oversight of Medicaid rates to ensure access to care is maintained. Therefore, we recommend reaffirmation of H-290.965 in lieu of adoption of R2.

III. Third Resolve
The third Resolve asks the AMA-MSS to review discrepancies in Medicaid managed care plans in light of the case that was brought in Armstrong v. Exceptional Child Center, Inc. CMS response has already been generated to this issue in 2015 regarding comments that the CMS add more specificity to managed care plans. Their response was that states and managed care plans should first work together to achieve beneficial outcomes before adopting specific mechanisms in managed health care plans. Therefore, it seems to be of no benefit for the AMA to support a study that has recently been answered by the CMS already. Based on the final CMS ruling in 2016, we recommend that R3 not be adopted.

IV. Fourth Resolve
The fourth Resolve asks the AMA-MSS to support identifying a solution for providers and beneficiaries to rectify discrepancies in reimbursement rates and enforce the Equal Access Provision at a local level. The primary method for judicial enforcement was previously only permissible through the Supremacy Clause of the United States Constitution, establishing federal laws as the supreme law over any decision made by the state or lower body. These arguments would then center around the understanding that CMS rulings as a federal body would supersede any state decisions on reimbursements, regardless of the budgetary constraints or peripheral circumstances that may have influenced the change in payment rates.

Since there are few remaining judicial process for providers and beneficiaries to seek enforcement of the equal access provision under Medicaid, the identification of non-judicial processes for the enforcement of Medicaid provisions is key to ensuring local compliance with CMS rates and rulings. This, again, is covered by AMA policy H-290.965, part 4. H-290.965 resonates with the current stance of this committee after reviewing the decision and consequences of Armstrong, and we agree that it sufficiently covers how we believe the AMA should respond to this situation. Therefore, we recommend that the AMA-MSS not adopt the fourth Resolve as written, and instead reaffirm H-290.965 in lieu of this Resolve. Reaffirmation of this policy will continue to bring attention to this timely, crucial problem and reassert the need for additional mechanisms to be developed in ensuring state compliance with CMS rules.

RECOMMENDATIONS

1. Your CEQM recommends the first Resolve of Resolution 35, I-16, be amended by deletion to read as follows:

RESOLVED, That our AMA-MSS raise awareness about the rulemaking process of the Administrative Procedure Act (APA) to encourage health care provider...
2. Your CEQM recommends the third Resolve of Resolution 35, I-16, be amended by deletion to read as follows:

RESOLVED. That our AMA-MSS support a study that reviews network adequacy standards for Medicaid managed care plans in light of providers and beneficiaries no longer having an implied right of action under the Supremacy Clause to enforce the Equal Access Provision [Section 30(A)] of the Medicaid Act; and be it further


Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.

12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.

13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.

4. Your CEQM recommends MSS Resolution 35 be adopted as amended and the remainder of this report be filed.

ACKNOWLEDGMENTS

This report was assembled by members of the 2017-18 Committee on Economics and Quality Medicine (Ajeet Singh, Mohsin Mukhtar, Eric Lakey, Ankita Brahmaroutu, Andrew Glick, and Hillary Landau).

REFERENCES


Subject: Update to IOPs
Presented by: Helene Nepomuceno, Chair
Referred to: MSS Reference Committee (Rachel Ekaireb, Kevin Qin, Co-Chairs)

INTRODUCTION
At A-17, the Medical Student Section Governing Council (GC) proposed IOP changes in GC Report A A-17. The report was passed by the Assembly and is awaiting review by the Board of Trustees after I-17 for finalization of the report. However, after careful evaluation of the effects of the updates, the GC has concerns regarding elections and appointments as discussed in this report.

ELIGIBILITY OF CHAIR-ELECT
Medical students have a limited number of years in medical school to be involved with the AMA as a part of the Medical Student Section (MSS). Given the limited number of opportunities, the section must balance electing individuals who are the most qualified with making leadership opportunities available to a diverse distribution of members. GC Report A A-17 recommended changes to the IOPs that allow councilors to be elected as Chair-Elect during their term as councilor. This would effectively let one student fill two leadership roles, as the Chair-Elect is a funded member of the Governing Council. Unlike Chair-Elect, Immediate Past Chair is a non-voting, non-funded position and therefore does not take away an opportunity when serving dual roles in the same way that Chair-Elect would. After discussions with your councilors and staff, we conclude that the benefits of allowing a councilor to run for additional leadership in the section do not outweigh the benefits of providing the most opportunities to the most members.

IMPARTIAL OVERSIGHT OF APPOINTMENTS
As part of the Governing Council’s continuing commitment to transparency and fairness, your GC would like to further ensure that the appointment process is fair for all applicants. Currently, the responsibility to both elucidate conflicts of interest and coordinate the appointments process falls on the MSS Chair. In this update, your GC proposes an impartial observer be present for all discussion, while noting that this addition must not hinder the ability of the GC to openly discuss all the positive aspects and negative aspects of each candidate. Therefore, your GC recommends that the Medical Student Trustee be present as an impartial observer to the process.

RECOMMENDATIONS
That the AMA-MSS amend IOP VI.B.1 by deletion as follows:

1. MSS members shall not hold an AMA Council or AMA Liaison position as well as a Governing Council position or the MSS Student Trustee position at the same time for more than two months, unless their Governing Council position or MSS Student Trustee position will conclude within 2 months of when their term as a member of an AMA Council or AMA Liaison begins. The only exception shall be that a MSS member may hold an AMA Council or AMA Liaison position and the position of Chair-elect or Immediate Past Chair simultaneously.

That the AMA-MSS amend IOP XI.C.5 by addition as follows:

1. In any discussion or selection of candidates for appointment to Council or Liaison positions, all Governing Council members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this discussion.

   a. The MSS Chair, or their designee, shall be responsible for ensuring a fair and thorough evaluation process by the Governing Council.

   b. To ensure that appointments are free from conflicts of interest, the Medical Student Trustee will be present as an impartial observer for all discussions of candidates.
American Medical Association
Medical Student Section Delegation Report
Annual Meeting of the House of Delegates - June 10-14, 2017

Reference Committee AC&B
Summary
- 31 Total items
- 14 items supported and 1 item opposed: 14 by policy, 1 by caucus vote
- 3 MSS items: 2 adopted and 1 adopted as amended

Reports
BOT Report 15 - No Compromise on Anti-Female Genital Mutilation Policy
- Recommendations:
  Reaffirmation of H-525.980 in lieu of Resolution 005-I-16
  - MSS Position: Support, just speak to policy
  - MSS Policy Supporting Position: 525.022MSS
  - MSS Authored?: No

CEJA Report 1 - Amendment to E-2.3.2 Professionalism in Social Media
- Recommendations:
  The Council on Ethical and Judicial Affairs recommends that Opinion E-2.3.2, “Professionalism in the Use of Social Media,” be amended by addition as follows and that the remainder of this report be filed:
  The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar opportunities can support physicians’ personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship.
  Physicians should weigh a number of considerations when maintaining a presence online:
  (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
  (b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.
  (c) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there
permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
(d) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.
(e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
(f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
(g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)
Modify HOD/CEJA Policy

- MSS Position: Support
- MSS Policy Supporting Position: 140.020MSS, 480.009MSS, 480.017MSS, 480.019MSS, 140.030MSS, 160.029MSS
- MSS Authored?: No

CEJA Report 3 - Ethical Physician Conduct in the Media

- Recommendations:
Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative.

Physicians involved in the media environment should be aware of their ethical obligations to patients the public, and the medical profession; and that their conduct can affect their medical colleagues, other healthcare professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:
(a) Always remember that they are physicians first and foremost, and must uphold the values and norms of the medical profession.
(b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.
(c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.
(d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:
   (i) accurate
   (ii) inclusive of known risks and benefits
   (iii) based on valid scientific evidence and insight gained from professional experience
(e) Confine their medical advice to their primary area(s) of expertise, and clearly distinguish the limits of their medical knowledge where appropriate.
(f) Refrain from making clinical diagnoses about individuals (e.g. public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.
(g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.
(h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts.

(New HOD/CEJA Policy)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 140.030MSS
- **MSS Authored?:** No, but original resolution referred to CEJA was from MSS

CEJA Opinion 1 - Collaborative Care
- **Recommendations:** Opinion report.
- **MSS Position:** Support
- **MSS Policy Supporting Position:** 160.014MSS, 160.015MSS
- **MSS Authored?:** No

Resolutions

**003 - Medical Spectrum of Gender**
- **Resolved:**
  RESOLVED, That our American Medical Association partner with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity as a complex interplay of gene expressions and biologic development. (Directive to Take Action)
  - **MSS Position:** Support with proposed amendment (amendment proposed by MSS using simple caucus vote)
  - **MSS Policy Supporting Position:** 65.015MSS, 65.017MSS, 295.190MSS, 310.041MSS, 65.008MSS, 65.002MSS, 65.012MSS, 65.021MSS
  - **MSS Authored?:** No

**006 - Increasing Access to Healthcare Insurance for Refugee Populations**
- **Resolved:**
RESOLVED, That our American Medical Association support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 250.028MSS, 250.020MSS
- MSS Authored?: Yes

008 - Promoting the Use of Appropriate LGBTQIA Language in Medical Documentation

- Resolved:

RESOLVED, That our American Medical Association support the inclusion of a patient’s biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable), surrogate identifications in medical documentation and related forms in a culturally sensitive manner.

- MSS Position: Support
- MSS Policy Supporting Position: 315.005MSS
- MSS Authored?: No

009 - Commercial Exploitation and Human Trafficking of Minors

- Resolved:

RESOLVED, That our American Medical Association support the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

- MSS Position: Support
- MSS Policy Supporting Position: 515.008MSS, 60.023MSS
- MSS Authored?: No

010 - Access to Basic Human Services for Transgender Individuals

- Resolved:

RESOLVED, That our American Medical Association oppose policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individual according to one’s gender identity.

- MSS Position: Support
- MSS Policy Supporting Position: 65.022MSS
- MSS Authored?: No

013 - Gender Identity Inclusion and Accountability in REMS

- Resolved:
RESOLVED, That our American Medical Association work with the United States Food and Drug Administration to develop a gender-neutral patient categorization model in Risk Evaluation and Mitigation Strategies programs, focusing exclusively on childbearing potential rather than gender identity.

- MSS Position: Support
- MSS Policy Supporting Position: 315.005MSS, 65.010MSS, 65.012MSS, 65.017MSS, 65.019MSS
- MSS Authored?: No

014 - The Need to Distinguish Between ‘Physician Assisted Suicide’ and ‘Aid in Dying’

- Resolved:
RESOLVED, That our American Medical Association, as a matter of organizational policy, when referring to what it currently defines as 'Physician Assisted Suicide' avoid any replacement with the phrase 'Aid in Dying' when describing what has long been understood by the AMA to specifically be 'Physician Assisted Suicide' (New HOD Policy)

RESOLVED, That our AMA develop definitions and a clear distinction between what is meant when the AMA uses the phrase 'Physician Assisted Suicide' and the phrase 'Aid in Dying' (Directive to Take Action)

RESOLVED That these definitions and distinctions be fully utilized by our AMA in organizational policy, discussions, and position statements regarding both 'Physician Assisted Suicide' and 'Aid in Dying' (New HOD Policy)

- MSS Position: Oppose
- MSS Policy Supporting Position: 140.034MSS, 140.026MSS
- MSS Authored?: No

015 - Appropriate Placement of Transgender Prisoners

- Resolved:
RESOLVED that our American Medical Association establish policy supporting the ability of transgender prisoners to be placed in facilities that are reflective of their affirmed gender status regardless of surgical status, if they so choose. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 65.012MSS, 65.019MSS, 65.022MSS
- MSS Authored?: No

016 - Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings against their Undocumented Parents

- Resolved:
RESOLVED, That our American Medical Association support that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported (New HOD Policy); and be it further
RESOLVED, That our AMA work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation. (Directive to Take Action)

- MSS Position: Support (new position established by caucus vote)
- MSS Authored?: No

017 - Improving Medical Care in Immigrant Detention Centers

 RESOLVED, That our American Medical Association issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend the U.S. Immigration and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 350.016MSS, 65.007MSS, 345.008MSS
- MSS Authored?: Yes

018 - Patient and Physician Rights Regarding Immigration Status

 RESOLVED, That our American Medical Association support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (New HOD Policy)

- MSS Position: Support
- MSS Authored?: Yes
Reference Committee A

Summary
- 32 Total items
- 13 Items supported, 1 opposed: 13 by policy, 1 by caucus vote
- No MSS items

Reports
CMS 6- Expansion of US Veteran’s Health Care Choices
- Recommendations:
The Council on Medical Service recommends that the following be adopted in lieu of Resolution 229-A-16 and that the remainder of the report be filed: 1. That our American Medical Association (AMA) continue to work with the Veterans Administration (VA) to provide quality care to veterans. 2. That our AMA continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. That our AMA reaffirm Policy H-510.985, which supports changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system and advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates. 4. That our AMA encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 5. That our AMA support consolidation of all the VA community care programs. 6. That our AMA encourage the VA to use external assessments as necessary to identify and address systemic barriers to care. 7. That our AMA support interventions to mitigate barriers to the VA from being able to achieve its mission. 8. That our AMA advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days. 9. That our AMA encourage the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care. 10. That our AMA encourage the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans. 11. That our AMA advocate for new funding to support expansion of the Veterans Choice Program.
- MSS Position: Support
- MSS Authored?: No

CMS 9- Capping Federal Medicaid Funding
- Recommendations: REPORT REFERRED
The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) advocate for the following safeguards if federal Medicaid funding is capped: a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced; b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services; c. Cost savings mechanisms should not decrease patient access to quality care or physician payment; d. The methodology for calculating the federal funding amount should take into consideration the state’s ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs; e. The federal funding amount should be based on the actual cost of health care services for each state; f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations; g. The federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index (e.g., consumer price index); h. Maximum cost-sharing requirements should not exceed five percent of family income; and i. The federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment and the ability of states to sustain their programs has not been compromised. 2. That our AMA advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding.

The following policy was adopted after which Council on Medical Service Report 9 was referred.

H-290.963, FEDERAL MEDICAID FUNDING 1. That our American Medical Association (AMA) oppose caps on federal Medicaid funding. 2. That our AMA advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding.

- MSS Position: Support
- MSS Policy Supporting Position: 165.012MSS, 165.007MSS, 165.009MSS, 165.015MSS, 165.019MSS
- MSS Authored?: No
Joint CMS/CSAPH-Value of Preventive Services

- **Recommendations:**
  
  The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) reaffirm Policy H-185.939, which supports the use of value-based insurance design in determining patient cost-sharing requirements based on the clinical value of a treatment. 2. That our AMA reaffirm Policy H-110.986, which supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. 3. That our AMA reaffirm Policy H-410.953, which calls for development processes that result in clinical practice guidelines that are trustworthy, rigorous, transparent, independent, and accountable. 4. That our AMA encourage committees that make preventive services recommendations to: a. Follow processes that promote transparency and clarity among their methods; b. Develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses; c. Rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available; d. Work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and e. Consider the development of recommendations on both primary and secondary prevention. 5. That our AMA encourage relevant national medical specialty societies to provide input during the preventive services recommendation development process. 6. That our AMA encourage comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making. 7. That our AMA encourage public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 160.022MSS, 170.001MSS, 180.013MSS
- **MSS Authored?:** No

**Resolutions**

101- Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis

- **Resolved Clauses:**

  RESOLVED, That our American Medical Association amend Policy H-20.895 by addition to read as follows:

  H-20.895, Pre-Exposure Prophylaxis (PrEP) for HIV 1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** No MSS Policy (check if MSS Res 26 was adopted) -Caucus voted to support
- **MSS Authored?:** No (RFS authored)
102- Establishing a Market System of Health System Financing and Delivery

- Resolved Clauses:

RESOLVED, That our American Medical Association reaffirm current policy, Patient Information and Choice H-373.998, advocating the following principles for achieving a realistic functional approach to a market system method of achieving cost-effectiveness in health care: 1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients’ interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. 2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. 3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit. 4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. 5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients’ freedom to select physicians and/or health plans of their choice. 6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (Reaffirm HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 155.003MSS, 315.007MSS, The MSS formally establishes support for the following HOD policy: H-373.998 Patient Information and Choice
- MSS Authored?: No

105- Opposition to Price Control

- Resolved Clauses:

RESOLVED, That our American Medical Association reaffirm our continued opposition to the use of price controls in any segment of the health care industry, and continue to promote market-based strategies to achieve access to and affordability of health care goods and services. (New HOD Policy)
107- Repeal and Replace Our Outdated Refundable Advanceable Tax Credit Policy

Resolved:
RESOLVED, That our American Medical Association study whether our current advanceable refundable tax credit policy is feasible given the worsening health care market failure that has occurred since this policy was developed (Directive to Take Action); and be it further
RESOLVED, That our AMA study the feasibility of a Medicare public option model as a model to improve access to care, considering options for modifications to benefits package and cost sharing. (Directive to Take Action)
- MSS Position: No position on R1 but Support R2
- MSS Policy Supporting Position: 165.017MSS, 165.020MSS
- MSS Authored?: No

110- Over-the-Counter Contraceptive Drug Access

Resolved:
RESOLVED, That our American Medical Association condemn age-based, cost-based, and other non-medical barriers to contraceptive drug access (New HOD Policy); and be it further
RESOLVED, That our AMA adopt policy supporting equitable access to over-the-counter (OTC) contraception, including those forms of contraception recommended for OTC sale, patient risk assessment screening tools, and prescribing by non-physicians (New HOD Policy); and be it further
RESOLVED, That our AMA support policy solutions that prohibit cost-sharing obstacles to OTC contraceptive drug access, and full coverage of all contraception without regard to prescription or OTC utilization, since all contraception is essential preventive health care (New HOD Policy); and be it further
RESOLVED, That our AMA advocate for the legislative and/or regulatory mechanisms needed to achieve improvements for OTC contraceptive drug access and quality. (New HOD Policy)
- MSS Position: Support
- MSS Policy Supporting Position: MSS formally supports HOD policies D-75.995 and H-170.968
- MSS Authored?: No

111- VA Technology-Based Eye Care Services

Resolved:
RESOLVED, That our American Medical Association encourage the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality healthcare to U.S. Veterans, including the Technology-Based Eye Care Services (TECS) program; (Directive to Take Action); and be it further
RESOLVED, That our AMA work with Congress to ensure that U.S. Veterans can access eye care through the Technology-Based Eye Care Services (TECS) program. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 520.005MSS, Formal Support for H-510.985
- MSS Authored?: No

113- The AMA Will Support Payment Parity at Medicare Levels for All Medicaid Services

- Resolved:

RESOLVED, That our American Medical Association support fair payment equity for all Medicaid providers at Medicare rates to assure that all Medicaid patients have access to a medical home and affordable, timely access to primary and specialty care services. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 65.016MSS, 165.011MSS
- MSS Authored?: No

114- Coverage for Preventive Care and Immunizations

- Resolved:

RESOLVED, That our American Medical Association identify as policy that routine preventive pediatric care, as recommended by the American Academy of Pediatrics (AAP), and immunizations, as recommended by the Centers for Disease Control and Prevention with approval of the AAP and American Academy of Family Physicians, be a required benefit of any public or private health insurance product and that it has first dollar coverage, without copays or deductibles. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 440.002MSS, 440.003MSS
- MSS Authored?: No

121- Advanced Care Planning Codes

- Resolved:

RESOLVED, That our American Medical Association assess the degree of use of CPT Codes 99497 and 99498 since they were established (Directive to Take Action); and be it further RESOLVED, That our AMA study the barriers to discussion about advanced care planning by physicians and patients (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for the expanded use of CPT Codes 99497 and 99498 when sufficient time and effort is spent in face-to-face contact with patients and families and when spread out over multiple clinical visits in order to satisfy the time requirements, due to the complexity of the subject matter. (New HOD Policy)

- MSS Position: Support per caucus vote
- MSS Policy Supporting Position: 140.007MSS
- MSS Authored?: No
123- Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in All Cases

- **Resolved:**
  RESOLVED, That our American Medical Association strongly advocate that all approved preventive services be included in all health plans (New HOD Policy); and be it further
  RESOLVED, That our AMA strongly urge members of the Congress and the President to support legislation to correct the oversight in the original legislation providing the benefit of colonoscopy screening with the inducement that the copay would not be required when a polyp or other lesion is found as part of the screening process. (Directive to Take Action)
  - MSS Position: Support
  - MSS Policy Supporting Position: 170.001MSS
  - MSS Authored?: No

125- Medicaid Substance Use Disorder Coverage

- **Resolved:**
  RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) to provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders (Directive to Take Action); and be it further
  RESOLVED, That our AMA work with CMS to establish clear billing and coding processes regarding the medical management and treatment of all substance use disorders. (Directive to Take Action)
  - MSS Position: Support
  - MSS Policy Supporting Position: MSS officially supports H-185.974
  - MSS Authored?: No
Reference Committee B

Summary
● 43 Total items
● 21 Items supported and 1 item opposed: 20 by policy, 2 by caucus vote
● 3 MSS items: 2 referred, 1 adopted

Reports
BOT 11 - Physician Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging
  • Recommendations:
    Amending policy H-478.997, “Guidelines for Patient-Physician Electronic Mail” with addition of below clauses:

    Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) requirements as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989.

    (4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.
    • MSS Position: Support
    • MSS Policy Supporting Position: 160.016MSS, 480.017MSS, 480.007MSS
    • MSS Authored?: No

BOT 13 - Closing Gaps in Prescription Drug Monitoring Programs
  • Recommendations:
    1. Careful review of literature and outcomes of PDMP on various measurements as determined in coordination with AMA task force to reduce opioid abuse.
    2. AMA advocate that VA pharmacies report to state PDMPs
    3. VA physicians be allowed to sign up for access to PDMP in the state of practice regardless of their licensing status in that state.
    4. AMA seek further clarification from the SAMHSA regarding the privacy requirements of opioid treatment programs in regard to reporting to state PDMPs.
    • MSS Position: Support
    • MSS Policy Supporting Position: 120.009MSS, Formal support of H-95.990
    • MSS Authored?: No

Resolutions
201 - Improving Drug Affordability
  • Resolved:
RESOLVED, That our American Medical Association support drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the
prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties--such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs)

RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment

RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients

RESOLVED, That our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

- MSS Position: Support
- MSS Policy Supporting Position: 100.014MSS, 100.015MSS, 270.031MSS
- MSS Authored?: No (RFS authored)

203 - AMA to Support Pharmaceutical Price Negotiation in US

- Resolved:

RESOLVED, That our American Medical Association prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

- MSS Position: Support
- MSS Policy Supporting Position: 100.014MSS
- MSS Authored?: No

205 - Limiting Medicare Part D Enrollee Costs

- Resolved:

RESOLVED, That our American Medical Association advocate for a Medicare Part D limiting charge for prescription medications (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for Medicare Part D annual out-of-pocket limit. (Directive to Take Action)

- MSS Position: Support (after caucus vote to establish new position)
- MSS Policy Supporting Position: None. Related policies include 100.014MSS, 165.004MSS, 165.007MSS, 315.007MSS
- MSS Authored?: No
207 - Sky Rocketing Drug Prices

- **Resolved:**

RESOLVED, That our American Medical Association strongly advocate for policies, regulations and legislation that protect patients from sky rocketing exorbitant prices for previously affordable drugs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for an “out of pocket” maximum dollar amount for total drug costs for our patients not to exceed $500 per month. (Directive to Take Action)

- MSS Position: Support R1, no position on R2
- MSS Policy Supporting Position: 100.014MSS; Formal support of H-110.988, H-110.989, D-330.954
- MSS Authored?: No

208 - Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States

- **Resolved:**

RESOLVED, That our AMA amend H-160.903 by addition to read as follows:

Eradicating Homelessness H-160.903

Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) **will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (Modify Current HOD Policy)

- MSS Position: Support
- MSS Authored?: Yes

214 - Medical Liability Coverage Through the Federal Tort Claims Act

- **Resolved:**

RESOLVED, That our American Medical Association seek legislation that would lead to malpractice insurance coverage through the Federal Tort Claims Act for all physicians who participate in Medicare and/or Medicaid and all federal insurance plans.

- MSS Position: Support
- MSS Authored?: No

216 - Electronically Prescribe Controlled Substances Without Added Processes
Resolved:
RESOLVED, That our American Medical Association advocate for full electronic prescribing of all prescriptions, without additional cumbersome electronic verification, including Schedule 2-5 controlled substances, eliminating the need for “wet signed” paper prescriptions and faxes for specific classes of prescriptions.
  - **MSS Position:** Oppose (after caucus vote to establish new position)
  - **MSS Policy Supporting Position:** None. Related policies include 270.009MSS; Formal support of H-120.960, D-120.958
  - **MSS Authored?:** No

217 - Inappropriate Request for DEA Numbers

Resolved:
RESOLVED, That our American Medical Association create a national registry or database where physicians can report inappropriate uses or requests for their DEA numbers (Directive to Take Action); and be it further

RESOLVED, That our AMA educate or seek penalties for those entities requesting or requiring use of DEA numbers outside of the prescribing of controlled substances (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the federal government to monitor and shut down any electronic means, including websites, that collect and distribute providers' DEA numbers, which would serve to protect the public and minimize the "hassle factor" for physicians.
  - **MSS Position:** Support
  - **MSS Policy Supporting Position:** 120.009MSS, 270.009MSS
  - **MSS Authored?:** No

218 - Licensing of Electronic Health Records

Resolved:
RESOLVED, That our American Medical Association develop model legislation for licensing electronic health records with a focus on ensuring system interoperability. (Directive to Take Action).
  - **MSS Position:** Support
  - **MSS Policy Supporting Position:** Formal support of D-478.996, D-478.994
  - **MSS Authored?:** No

219 - Integration of Drug Price Information into Electronic Medical Records

Resolved:
RESOLVED, That our American Medical Association support the incorporation of estimated patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden (New HOD Policy)
RESOLVED, That our AMA collaborate with invested stakeholders, such as physician groups, Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden. (Directive to Take Action)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 315.007MSS, 155.003MSS, 155.004MSS, 155.001MSS
- **MSS Authored?:** Yes

### 220 - Accountability of 911 Emergency Services Funding

**Resolved:**

RESOLVED, That our American Medical Association encourage federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services. (Directive to Take Action)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 270.034MSS
- **MSS Authored?:** Yes

### 223 - Tax Deductions for Direct-to-Consumer Advertising

**Resolved:**

RESOLVED, That our American Medical Association support legislation to prohibit costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 105.003MSS
- **MSS Authored?:** No

### 227 - Improving Clinical Utility of Medical Documentation

**Resolved:**

RESOLVED, That our American Medical Association advocate for appropriate, effective, and less burdensome requirements in the use of electronic health records.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** Formal support of D-478.996, D-478.995
- **MSS Authored?:** No

### 228 - Free Speech Applies to Scientific Knowledge

**Resolved:**

RESOLVED, That our American Medical Association work with members of the U.S. Congress and the Trump Administration to assure that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment (Directive to Take Action); and be it further
RESOLVED, That our AMA oppose any federal policies, orders, laws, or directives that alter or prevent the free dissemination of scientific and technological information and research that is by right and law the property of the American people and support legal proceedings in opposition to violations of scientific integrity policies. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 460.018MSS
- MSS Authored?: No

231 - Naloxone Price Increase

- Resolved:

RESOLVED, That our American Medical Association amend existing AMA Policy, H-95.932, 10 “Increasing Availability of Naloxone,” by addition and deletion as follows:

1. Our AMA supports legislative, and regulatory, and national advocacy efforts that increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. (Modify Current HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 100.007MSS, 100.010MSS, 100.013MSS, 100.014MSS
- MSS Authored?: No

233 - Regulation of Physician Assistants

- Resolved:

RESOLVED, That our American Medical Association advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel (New HOD Policy);

RESOLVED, That our AMA oppose legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies’ authority and purview. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 160.014MSS, 160.015MSS
- MSS Authored?: No

234 - Protections for Patients with Genetic Conditions

- Resolved:

RESOLVED That our American Medical Association actively oppose the Preserving Employee Wellness Programs Act (Directive to Take Action)
RESOLVED That our AMA support efforts to preserve nondiscrimination protections established by the Genetic Information Nondiscrimination Act and the Americans with Disabilities Act. (New HOD Policy)

- MSS Position: Support
- MSS Authored?: No

236 - Retail Price of Drugs Displayed in Direct-to-Consumer Pharmaceutical Advertising

- Resolved:

RESOLVED, That our American Medical Association advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 105.001MSS, 105.002MSS, 105.003MSS, 155.003MSS; Formal support of H-105.988, H-373.998
- MSS Authored?: No

237 - Protection of Clinician-Patient Privilege

- Resolved:

RESOLVED, That our American Medical Association advocate to the relevant national bodies for the clinician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 without regard to where care is received.

- MSS Position: Support
- MSS Policy Supporting Position: 160.029MSS, 270.004MSS
- MSS Authored?: No

239 - AMA Support for Texting as Approved HIPAA Communication

- Resolved:

RESOLVED, That our American Medical Association collaborate with medical technology companies and the federal government to improve texting platforms so that more commercially available devices comply with HIPAA without having to utilize expensive and complex encryption technology (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the relaxation of HIPAA rules regulating the use of commercially available devices to transfer protected health information. (New HOD Policy)

- MSS Position: Support R1, No position on R2
- MSS Policy Supporting Position: 480.009MSS, Formal Support of D-480.975
- MSS Authored?: No
Reference Committee C

Summary
- 34 Total items
- 24 Items supported and 1 item opposed: 18 by policy, 7 by caucus vote
- 3 MSS items: 1 adopted and 2 adopted as amended

Reports
CME Report 1 - Council on Medical Education Sunset Review of 2007 House Policies
- **Recommendations:** Lengthy list of sunsetted, retained, and revised policies.
- **MSS Position:** Support. Also supported amendment from New England Delegation to oppose the sunset of H-295.908 (established new position by caucus vote).
- **MSS Policy Supporting Position:** 295.013MSS, 310.003MSS
- **MSS Authored?** No

CME Report 3 - Obesity Education
- **Recommendations:**
  1. That our American Medical Association (AMA) make this report available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians. (Directive to Take Action)
  2. That AMA Policy D-440.980 (5), “Recognizing and Taking Action in Response to the Obesity Crisis,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)
- **MSS Position:** Support
- **MSS Policy Supporting Position:** 440.013MSS
- **MSS Authored?** No

CME Report 5 - Options for Unmatched Medical Students
- **Recommendations:** This was an informational report only.
- **MSS Position:** Support
- **MSS Policy Supporting Position:** 310.050MSS
- **MSS Authored?** No

CME 6 - Standardizing the Allopathic Residency Match System and Timeline
- **Recommendations:**
  1. That our American Medical Association (AMA) support the movement toward a unified and standardized residency application and match system for all non-military residencies. (New HOD Policy)
  2. That our AMA encourage the Association of University Professors of Ophthalmology, the American Urological Association, and other appropriate stakeholders to move ophthalmology and urology to the National Resident Matching Program. (Directive to Take Action)
3. That our AMA encourage the National Resident Matching Program to develop a process by which sequential matches could occur for those specialties that require a preliminary year of training, allowing a match to the GY2 position, followed later in the year by a match to a GY1 position, thus reducing application and travel costs for applicants. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 310.051MSS, 295.136MSS, 310.001MSS
- MSS Authored?: No

CME 7 - Expansion of Public Service Loan Forgiveness

- Recommendations:
  1. The Council asks AMA to encourage 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.
  2. That our AMA rescind Policy D-305.993 (10), as having been fulfilled by this report. (Rescind HOD Policy)
  3. That our AMA reaffirm Policy D-305.993 (1-9), which asks that the AMA advocate against a cap on federal loan forgiveness programs but also advocate that any cap on loan forgiveness under the PSLF program be at least equal to the principal amount borrowed. (Reaffirm HOD policy)
  4. That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility. (Directive to Take Action)
  5. That our AMA encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed. (Directive to Take Action)
  6. That our AMA encourage medical school financial advisors to promote to medical students the Students to Service Loan Repayment Program of the National Health Service Corps (NHSC) 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. (Directive to Take Action)
  7. That our AMA strongly advocate that any restrictive changes to the PSLF take effect after all individuals currently within their PSLF eligibility period are “aged out” of the PSLF program under the conditions in place when they began their eligibility. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 200.002MSS, 305.001MSS, 305.003MSS, 305.009MSS, 305.075MSS
- MSS Authored?: No

CME 9 - Feasibility and Appropriateness of Transferring Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools

- Recommendations:
transferring jurisdiction of clinical skills examinations to medical schools, unless and until a viable alternative can be identified. (Rescind HOD Policy)

2. That AMA Policy D-295.988 (3) be amended by addition and deletion to read as follows: “3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; and (d) engage in a transparent evaluation of basing this examination within our nation’s medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.” (Modify Current HOD Policy)

3. That our AMA encourage development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination. (New HOD Policy)

4. That our AMA, through the Council on Medical Education, continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. (New HOD Policy)

   MSS Position: Oppose. Supported amended language proposed by CME (established by simple caucus vote).


   MSS Authored?: No

Resolutions
301 - Mental Health Disclosures on Physician Licensing Applications

   Resolved:
RESOLVED, That our American Medical Association encourage state medical boards to consider physical and mental conditions similarly (New HOD Policy);
RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine (New HOD Policy); and be it further
RESOLVED, That our AMA amend policy Licensure Confidentiality H-275.970 by addition and deletion to read as follow:

   Licensure Confidentiality H-275.970: The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained
on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician’s practice of medicine or presents a public health danger. That, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant’s current state of health does not interfere with his or her ability to practice medicine. (Modify Current HOD Policy);

and be it further

RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. (New HOD Policy)

- **MSS Position**: Support
- **MSS Policy Supporting Position**: 345.007MSS, 165.019MSS, 295.001MSS, 295.137MSS, 295.164MSS, 345.004MSS, 345.012MSS
- **MSS Authored?**: No

**303 - Addressing Medical Student Mental Health Through Data Collection and Screening**

- **Resolved**: RESOLVED, That our American Medical Association encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide (New 21 HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (New HOD Policy)

- **MSS Position**: Support
- **MSS Policy Supporting Position**: 345.012MSS, 295.001MSS, 295.137MSS, 295.164MSS, 345.004MSS, 345.009MSS
- **MSS Authored?**: Yes

**304 - Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding**

- **Resolved**: RESOLVED, That our American Medical Association support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are
currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 255.006MSS, 255.001MSS
- **MSS Authored?:** Yes

307 - Formal Business and Practice Management Training During Medical Education

- **Resolved:**

RESOLVED, That our American Medical Association encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum.

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 295.011MSS, Formal support of D-295.958
- **MSS Authored?:** No

308 - Immigration Reform Impacts on International Medical Graduate Training and Patient Access

- **Resolved:**

RESOLVED, That our American Medical Association advocate for the timely processing of visas for physicians to fill residency and fellowship training spots (New HOD Policy); and be it further

RESOLVED, That our AMA study the current impact of immigration reform efforts on residency and fellowship training programs, physician supply, and timely access of patients to healthcare throughout the US (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates by the 2017 Interim Meeting such study findings, including appropriate proposals to advocate on behalf of international medical graduate physicians and their patients. (Directive to Take Action)

- **MSS Position:** Support (new position established by caucus vote)
- **MSS Policy Supporting Position:** None. Relevant policies include 255.001MSS.
- **MSS Authored?:** No

309 - Future of the USMLE: Examining Multi-Step Structure and Score Usage

- **Resolved:**
RESOLVED, That our American Medical Association work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to study alternate means of scoring USMLE exams. (Directive to Take Action)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 295.188MSS, 295.182MSS, 295.174MSS, 295.150MSS
- **MSS Authored?:** Yes

310 - Breast Pump Accommodations During Medical Licensing Exams

- **Resolved:**

RESOLVED, That our American Medical Association encourage that the accommodation of breastfeeding individuals in all medical licensing exams in all specialties be allowed if the individual can provide a note from their physician (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that accommodations include necessary time per exam day in addition to the standard pool of scheduled break time found in the specific exam as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. (New HOD Policy)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 295.183MSS, 245.002MSS
- **MSS Authored?:** No

311 - Support of International Medical Students and Graduates

- **Resolved:**

RESOLVED, That our American Medical Association recognize the unique contributions and affirm our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine (New HOD Policy); and be it further

RESOLVED, That our AMA oppose changes to immigration policies for international and foreign-born medical graduates and students that use country of origin to restrict visa procurement and ability to travel outside of the U.S. and return with a visa. (New HOD Policy)

- **MSS Position:** Support (new position established by caucus vote)
- **MSS Policy Supporting Position:** None. Relevant policies include 255.001MSS.
- **MSS Authored?:** No

312 - Supporting International Medical Graduates and Students

- **Resolved:**
RESOLVED, That our American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. (New HOD Policy)

- **MSS Position:** Support (new position established by caucus vote)
- **MSS Policy Supporting Position:** None. Relevant policies include 255.001MSS.
- **MSS Authored?:** No

313 - *Study of Declining Native American Medical Student Enrollment*

- **Resolved:**

  RESOLVED, That our American Medical Association partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study. (Directive to Take Action)

  - **MSS Position:** Support
  - **MSS Policy Supporting Position:** 350.011MSS
  - **MSS Authored?:** No

314 - *Educating a Diverse Physician Workforce*

- **Resolved:**

  RESOLVED, That our American Medical Association develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population (Directive to Take Action); and be it further

  RESOLVED, That our AMA provide on-line educational materials for its membership that address cultural, racial and religious issues in patient care (Directive to Take Action); and

  RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from under-represented minority groups, to healthcare careers (Directive to Take Action); and be it further

  RESOLVED, That our AMA create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs (Directive to Take Action); and be it further

  RESOLVED, That our AMA recommend that medical school admissions committees use holistic evaluation of admission applicants, taking into account the diversity of preparation and the variety of talents that applicants bring to their education (New HOD Policy); and be it further

  RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to race and ethnicity collected from Electronic Residency
Application Service (ERAS) applications through the National Residency Matching Program (NRMP) (New HOD Policy); and be it further
RESOLVED, That our AMA continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. (Directive to Take Action)

- MSS Position: Support
- MSS Authored?: No

315 - Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians

- Resolved:
RESOLVED, That our American Medical Association reaffirm AMA Policies H-90.968, “Medical Care of Persons with Developmental Disabilities,” and H-90.969, “Early Intervention for Individuals with Developmental Delay” (Reaffirm HOD Policy); and be it further
RESOLVED, That our AMA recognize the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community (New HOD Policy); and be it further
RESOLVED, That our AMA support efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities (New HOD Policy); and be it further
RESOLVED, That our AMA encourage allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities (New HOD Policy); and be it further
RESOLVED, That our AMA encourage graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities (New HOD Policy); and be it further
RESOLVED, That our AMA encourage continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. (New HOD Policy)
- MSS Position: Support
- MSS Policy Supporting Position: 90.007MSS
- MSS Authored?: No

317 - Immigration
- Resolved:
RESOLVED, That our American Medical Association lobby the US Congress and other appropriate US government officials to exempt physicians from any current or future ban or suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa. (Directive to Take Action)

- MSS Position: Support (new position established by caucus vote)
- MSS Policy Supporting Position: None. Relevant policies include 255.001MSS.
- MSS Authored?: No

320 - Cultural Competence in Standardized Patient Programs within Medical Education

- Resolved:
- RESOLVED, That our American Medical Association amend existing AMA Policy H-295.897, “Enhancing the Cultural Competence of Physicians” by addition as follows:
  7. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills. (Modify Current HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 295.190MSS
- MSS Authored?: No

321 - Continued Support of H-1B Visa Programs for International Medical Graduates

- Resolved:
- RESOLVED, That our American Medical Association urge the Trump Administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities. (Directive to Take Action)

- MSS Position: Support (new position established by caucus vote)
- MSS Policy Supporting Position: None. Relevant policies include 255.001MSS.
- MSS Authored?: No

323 - Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved/Economically Depressed Areas

- Resolved:
- RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 310.003MSS; Formal support of D-305.967, H-305.929, H-310.917
- MSS Authored?: No

324 - Improve HRSA Projections of the Physician Workforce

- Resolved:
RESOLVED, That our American Medical Association work with the Health Resources & Service Administration and specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforce (Directive to Take Action)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 350.012MSS
- **MSS Authored?:** No

325 - *Ensure an Effective H-1B Visa Program to Protect Patient Access to Care*

**Resolved:**
RESOLVED: That our American Medical Association proactively work with appropriate officials to secure an exemption of medical professionals from the suspension of and any future modifications to the H-1B visa program, in order to allow for efficient entry of international physicians into the United States. (Directive to Take Action)

- **MSS Position:** Support (new position established by caucus vote)
- **MSS Policy Supporting Position:** None. Relevant policies include 255.001MSS.
- **MSS Authored?:** No

326 - *Support for International Medical Graduates and Students*

**Resolved:**
RESOLVED, That the American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States by persons based on their country of origin and/or religion who currently have legal visas, including permanent resident status (green card) and student visas (New HOD Policy); and be it further

RESOLVED, That the AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. (New HOD Policy)

- **MSS Position:** Support (new position established by caucus vote)
- **MSS Policy Supporting Position:** None. Relevant policies include 255.001MSS.
- **MSS Authored?:** No
Reference Committee D

Summary

- 19 Total items
- 10 Items supported: 10 by policy, 1 by caucus vote
- 2 MSS items, 2 adopted

Reports

CSAPH 3-Strategies to Reduce the Consumption of Beverages with Added Sweeteners

- Recommendations:

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 417-A-16 and the remainder of this report be filed:

1. That our AMA acknowledge the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging. (New HOD Policy)

2. That our AMA encourage continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system. (New HOD Policy)

3. That our AMA encourage hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs. (New HOD Policy)

4. That our AMA encourage physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students. (New HOD Policy)

5. That Policy H-150.933, “Taxes on Beverages with Added Sweeteners,” which encourages consumer education about SSBs, encourages SSB tax revenues to be used for obesity prevention, and advocates for continued research into the potentially adverse effects of consumption of non-calorically sweetened beverages, be reaffirmed. (Reaffirm HOD Policy)

6. That Policy H-150.960, “Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools,” be amended by addition and deletion to read as follows:

H-150.960, Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools: The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, which that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices which that contribute to the nutritional needs of the students. (Modify HOD Policy)

7. That Policy H-150.944, “Combating Obesity and Health Disparities,” be amended by addition and deletion to read as follows: H-150.944, Combating Obesity and Health Disparities: Our AMA
supports efforts to: (1) reduce health disparities by basing food assistance programs on the
health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian
foods, and healthful dairy and nondairy beverages in school lunches and food assistance
programs; and (3) ensure that federal subsidies encourage the consumption of products foods
and beverages low in fat, added sugars, and cholesterol. (Modify HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 150.033MSS, 150.015MSS, 150.017MSS,
  150.022MSS, 215.004MSS
- MSS Authored?: No

**Resolutions**

404-Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of More
Incarcerated Persons

- Resolved:
RESOLVED, That our American Medical Association support the implementation of routine
screening for Hepatitis C virus (HCV) in prisons (New HOD Policy); and be it further
RESOLVED, That our AMA advocate for the initiation of treatment for HCV in all incarcerated
patients with the disease and seeking treatment (New HOD Policy); and be it further
RESOLVED, That our AMA support negotiation for affordable pricing for therapies to treat and
cure HCV among correctional facility health care providers, correctional facility health care
payors, and drug companies to maximize access to these disease-altering medications. (New
HOD Policy)

- MSS Position: Support R2
- MSS Policy Supporting Position: 440.040MSS, 440.059MSS, 20.010MSS
- MSS Authored?: No

407- SNAP Reform to Improve Health and Combat Food Deserts

- Resolved:
RESOLVED, That Our American Medical Association request that the federal government
support Supplemental Nutrition Assistance Program (SNAP) initiatives to (1) incentivize
healthful foods and disincentivize or eliminate unhealthful foods and (2) harmonize SNAP food
offerings with those of Special Supplemental Nutrition Program for Women, Infants, and
Children (WIC). (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 150.028MSS, 150.018MSS, 150.020MSS
- MSS Authored?: No

408- Increased Oversight of Suicide Prevention Training for Correctional Facility Staff

- Resolved:
RESOLVED, That our American Medical Association strongly encourage all state and local
correctional facilities to develop a suicide prevention plan that meets current National
Commission on Correctional Health Care guidelines (New HOD Policy); and be it further
RESOLVED, That our AMA strongly encourage all state and local correctional facility officers to undergo suicide prevention training annually. (New HOD Policy)
- MSS Position: Support
- MSS Policy Supporting Position: 270.033MSS
- MSS Authored?: Yes

410-Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals
- Resolved:
RESOLVED, That our American Medical Association amend current policy H-440.845 by addition to read as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H- 5 440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV; (5) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (6) recognize correctional physicians, and physicians in other public healthcare settings, as key stakeholders in the development of HCV treatment guidelines. (Modify current HOD policy)
- MSS Position: Support
- MSS Policy Supporting Position: 440.040MSS, 440.059MSS
- MSS Authored?: Yes

411- Preserving Vaccine Policy in the United States
- Resolved:
RESOLVED, That our American Medical Association support evidence that vaccines are an effective mechanism for controlling communicable disease and protecting public health (New HOD Policy); and be it further
RESOLVED, That our AMA continue to support vaccine guidance that is evidence-based (New HOD Policy); and be it further
RESOLVED, That our AMA oppose the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines. (New HOD Policy)
- MSS Position: Support R1 and R2, Support R3 via Caucus vote
- MSS Policy Supporting Position: 165.009MSS, 440.002MSS, 440.003MSS, 440.035MSS, 440.051MSS
- MSS Authored?: No
414- Imposing Taxes on Sugar-Sweetened Beverages

- **Resolved:**

RESOLVED, That our American Medical Association endorse the efforts of states, counties, and cities that seek to impose sugary beverage taxes to reduce obesity and the attendant risks of chronic disease (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage state and local medical societies to support the adoption of state and local taxes on sugar-sweetened soft drinks. (New HOD Policy)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 150.017MSS, 150.022MSS, 215.004MSS
- **MSS Authored?:** No

416-Policy and Economic Support for Early Child Care

- **Resolved:**

RESOLVED, That our American Medical Association advocate for improved social and economic support for paid family leave to care for newborns, infants and young children (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members. (New HOD Policy)

- **MSS Position:** Support R1, No position R2
- **MSS Policy Supporting Position:** 270.032MSS, 200.003MSS, 310.049MSS
- **MSS Authored?:** No

417-Mandatory Public Health Reporting of Law-Enforcement-Related Injuries and Deaths

- **Resolved:**

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law-enforcement-related injuries and deaths and make law-enforcement-related deaths a notifiable condition. (New HOD Policy)

- **MSS Position:** Support
- **MSS Policy Supporting Position:** 440.054MSS
- **MSS Authored?:** No

1003- Evidence-Based Vaccination Recommendation

- **Resolved:**

RESOLVED, That our American Medical Association support the rigorous scientific process of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices and encourage education of parents and patients on the safety, risks, and benefits of vaccination (New HOD Policy); and be it further

RESOLVED, That our AMA support both national and state scientifically-based policies that promote the safety of vaccinations and effectively serve to increase the number of individuals vaccinated against communicable diseases. (New HOD Policy)

- **MSS Position:** Support
- MSS Policy Supporting Position: 440.002MSS, 440.003MSS, 440.035MSS, 440.051MSS
- MSS Authored?: No
Reference Committee E

Summary
- 28 Total items
- 15 Items supported: 15 by policy, by caucus vote
- 6 MSS items, 3 adopted

Reports
CSAPH 1 - CSAPH Sunset Review of 2007 House Policies
- Recommendations:
The Council on Science and Public Health recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the Report be filed. (Directive to Take Action)
  - MSS Position: Support
  - MSS Authored?: No

CSAPH 2 - Emerging Drugs of Abuse are a Public Health Threat
- Recommendations:
The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
  1. That Policy H-95.940, "Addressing Emerging Trends in Illicit Drug Use," be amended by addition and deletion as follows:

Addressing Emerging Trends in Illicit Drug Use

Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, and other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiological surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drug of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by the federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (Modify Current HOD policy)
  2. That our AMA participate as a stakeholder in a CDC/DEA taskforce for the development of a national forum for discussion of NPS-related issues. (Directive to Take Action)
    - MSS Position: Support
Resolutions
501-Airplane Emissions

- **Resolved:**
  - RESOLVED, That our American Medical Association urge the President and the Environmental Protection Agency to expeditiously publish regulations, including binding limits on carbon dioxide emissions and other hazardous byproducts, that will stimulate development of clean aviation technology. (Directive to Take Action)
  - **MSS Position:** Support
  - **MSS Policy Supporting Position:** 100.016MSS, 95.005MSS
  - **MSS Authored?:** Yes (resolution that triggered this report)

502-Access to Cosmetic Product Ingredients

- **Resolved:**
  - RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to mandate that all manufacturers of cosmetics, skincare products, nail polish, and sunscreens make their full ingredient lists available on the package and online to consumers
  - RESOLVED, That our AMA prepare a report to increase awareness of acrylate allergy, update potential sources of occupational and non-occupational exposure, and provide an update as to the best ways and barrier methods to avoid acrylate exposure by susceptible individuals, with a report back to the AMA HOD at the 2017 Interim Meeting.
  - **MSS Position:** Support
  - **MSS Policy Supporting Position:** 270.021MSS
  - **MSS Authored?:** No

503-Women and Mental Health

- **Resolved:**
  - RESOLVED, That our American Medical Association encourage key organizations to identify barriers in access to mental health services and improve treatment models in order to address gender disparities in mental health (Directive to Take Action); and be it further
  - RESOLVED, That our AMA publicize the impact of violence and social determinants on women's mental health (Directive to Take Action); and be it further
  - RESOLVED, That our AMA encourage the development of gender-specific risk factor reduction strategies, including gender sensitive services that focus on psychosocial resources and reproductive health, in order to improve women's mental health (Directive to Take Action); and be it further
  - RESOLVED, That AMA Policy H-420.953 “Improving Mental Health Services for Pregnant and Postpartum Mothers,” be amended by addition to read as follows:

H-420.953, Improving Mental Health Services for Pregnant and Postpartum Mothers
Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis through research, public awareness, and support programs. (Modify Current HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 420.004MSS
- MSS Authored?: No

504-Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks

- Resolved:
RESOLVED, That our American Medical Association work with partner organizations to provide education on the potential risks of cardiovascular or cerebrovascular disease in pregnant women, particularly among vulnerable populations (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for more research on ways to identify modifiable risk factors for preterm birth (PTB) and its association with cardiovascular or cerebrovascular disease in pregnant women. (Directive to Take Action)

- MSS Position: Support
- MSS Authored?: No

506-Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder

- Resolved:
RESOLVED, That our American Medical Association study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine for treatment of Opioid Use Disorder. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 120.013MSS
- MSS Authored?: Yes

507-Educating Physicians and Young Adults on Synthetic Drugs

- Resolved:
RESOLVED, That our American Medical Association amend existing AMA policy H-95.940 by addition to read as follows:

ADDRESSING EMERGING TRENDS IN ILLICIT DRUG USE

Our American Medical Association (AMA): (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor emerging trends in illicit and legal synthetic drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of
continuing medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.

- MSS Position: Support
- MSS Policy Supporting Position: 100.016MSS
- MSS Authored?: Yes

508-Support for Service Animals, Emotional Support Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership

- Resolved:
RESOLVED, That our American Medical Association (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit. (NewHOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 440.039MSS
- MSS Authored?: Yes

509- Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research

- Resolved:
RESOLVED, That our American Medical Association study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (Directive to Take Action)

- MSS Position: Support
- MSS Policy Supporting Position: 480.018MSS
- MSS Authored?: Yes

511-Future of Pain Care

- Resolved:
RESOLVED, That our American Medical Association convene a task force from organized medicine to discuss medicine’s response to the public health crisis of under treated and mistreated pain (Directive to Take Action); and be it further RESOLVED, That this task force explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options (Directive to Take Action); and be it further RESOLVED, That this task force discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain (Directive to Take Action); and be it further RESOLVED, That this task force involve many primary care, medical and surgical specialties that are involved in providing pain care. (Directive to Take Action)
• MSS Position: Support
• MSS Policy Supporting Position: 440.023MSS, 100.012MSS, 270.009MSS
• MSS Authored?: No

512-Advertising Restrictions and Limited Use of Dietary Supplements
• Resolved: RESOLVED, That our American Medical Association study the need for U.S. Food and Drug Administration regulation of dietary supplements.
  • MSS Position: Support
  • MSS Policy Supporting Position: 440.024MSS, 150.027MSS
  • MSS Authored?: No

514-Retinoblastoma Due to Pre-Natal Residential Pesticide Exposure
• Resolved: RESOLVED, That our American Medical Association encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma (New HOD Policy); and RESOLVED, That our AMA encourage physicians to discuss with patients the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma. (New HOD 25 Policy)
  • MSS Position: Support
  • MSS Authored?: No

524- Safe Injection Facilities
• Resolved: RESOLVED, That our AMA work with state and local health departments to achieve the legalization and implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. (Directive to Take Action)
  • MSS Position: Support
  • MSS Policy Supporting Position: 95.011MSS
  • MSS Authored?: Yes

525-Providing for Prescription Drug Donation
• Resolved: RESOLVED, That our American Medical Association advocate for new federal legislation that would allow nursing homes to recycle prescription drugs that are unused, sealed, and dated; and be it further
RESOLVED, That our AMA advocate for new federal legislation that would allow physician offices and clinics to donate prescription drugs that are unused, sealed, and dated to patients in need who are uninsured or underinsured; and be it further RESOLVED, That our AMA advocate for new federal legislation that would allow cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured.

- MSS Position: Support
- MSS Policy Supporting Position: 120.014MSS
- MSS Authored?: No
Reference Committee F

Summary
● 15 Total items
● 5 Items supported: 5 by policy, 0 by caucus vote
● 2 MSS items: 2 adopted as amended

Reports
BOT Report 17 - Equality for Future Meetings Organized or Sponsored by the AMA
● Recommendations:
The Board of Trustees recommends that Policy G-630.140 be amended by addition to read as follows in lieu of Resolution 602-I-16, and that the remainder of this report be filed:

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

● MSS Position: Support
● MSS Authored?: No

Resolutions
601 - Reinstate the AMA Commission to End Health Care Disparities
● Resolved:
RESOLVED, That our American Medical Association reinstate the Commission to Eliminate Health Care Disparities, including goals and objectives that are Specific, Measurable, Agreed Upon, Realistic and Time Related (SMART) metrics. (Directive to Take Action)

● MSS Position: Support
● MSS Authored?: No
603 - Sexual Orientation and Gender Identity Demographic Collection by the AMA

- **Resolved:**
  RESOLVED, That our AMA develop a plan with input from the Advisory Committee on LGBTQ Issues to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner. (New HOD Policy)
  - MSS Position: Support
  - MSS Policy Supporting Position: 530.025MSS
  - MSS Authored?: Yes

607 - AMA to Protect Human Health from the Effects of Climate Change by Ending Its Investments in Fossil Fuel Companies (Divestment)

- **Resolved:**
  RESOLVED, That our American Medical Association, Foundation, and any affiliated corporations, work in a timely and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (Directive to Take Action); and be it further
  RESOLVED, That our AMA, when fiscally responsible, choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption (Directive to Take Action); and be it further
  RESOLVED, That our AMA support efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers.
  - MSS Position: Support
  - MSS Policy Supporting Position: 135.015MSS
  - MSS Authored?: No

608 - Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine

- **Resolved:**
  RESOLVED, That our American Medical Association study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine on medical school campuses and in teaching hospitals (Directive to Take Action); and be it further
  RESOLVED, That our AMA study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine (Directive to Take Action); and be it further
RESOLVED, That our AMA identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites (Directive to Take Action).

- MSS Position: Support
- MSS Policy Supporting Position: 310.021MSS, 295.173MSS, 565.004MSS
- MSS Authored?: Yes (co-sponsored)
Reference Committee G

Summary
- 26 Total items
- 5 Items supported: 5 by policy, 0 by caucus vote
- 2 MSS items, 1 adopted

Reports
BOT 20- Study of Minimum Competencies and Scope of Medical Scribe Utilization
- Resolved:
The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:
2. That our AMA monitor the medical scribe industry periodically to identify important trends. (Directive to Take Action.)
3. That our AMA continue to review and promote strategies that help improve physician practice workflow. (Directive to Take Action.)
4. As this report has provided the requested study, that Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians” be amended by rescission of the fourth paragraph to read as follows:
   1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary—to create more transparency and support more informed decision making in the selection of EHRs.
   2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
   3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
   4) Our AMA will study medical scribe utilization in various health care settings. 5) Our AMA will make available the findings of the AmericanEHR Partners’ survey and report back to the House of Delegates. (Directive to Take Action.)
- MSS Position: Support
- MSS Policy Supporting Position: 275.012MSS
- MSS Authored?: Yes (resolution that triggered this report)

Resolutions
703-Certified Translational Services

- Resolved:

RESOLVED, That our AMA work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act.

- MSS Position: Support
- MSS Policy Supporting Position: 160.006MSS
- MSS Authored?: No

710-Payment of Medicaid Interpreter Services

- Resolved:

RESOLVED, That our American Medical Association support 1) access to interpreters for limited English proficient and hearing-impaired Medicaid patients; 2) regulations that require the Medicaid program and Medicaid managed care plans to arrange and pay for the services to relieve the burden on physicians; and 3) regulations that require physicians to be fully paid by the Medicaid program and Medicaid managed care plans for such services. (New HOD Policy)

- MSS Position: Support
- MSS Policy Supporting Position: 160.006MSS
- MSS Authored?: No

711-Expanding Access to Screening Tools for Social Determinants of Health

- Resolved:

RESOLVED, That our American Medical Association provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources (Directive to Take Action); and be it further

RESOLVED, That our AMA support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record (New HOD Policy); and be it further

RESOLVED, That our AMA support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.

- MSS Position: Support
- MSS Policy Supporting Position: 160.033MSS
- MSS Authored?: Yes

715-Prescription Availability for Weekend Discharges

- Resolved:

RESOLVED, That our American Medical Association work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient’s health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues. (Directive to Take Action)

- MSS Position: Support
- **MSS Policy Supporting Position**: 120.007MSS, 120.012MSS
- **MSS Authored?**: No
AMA-MSS NATIONAL SERVICE PROJECT
COMBATTING THE OPIOID EPIDEMIC

When: Saturday November 11, 2017
9:00 AM-12:00 PM

Where: University of Hawai‘i at Manoa
John A. Burns School of Medicine
Room MEB 301

Learn how to administer naloxone

Dispose of your unwanted medications

Learn from organizations in the Hawaii community
about how you can help combat the opioid epidemic

Everyone welcome! Serving light refreshments
Parking available at Lot C and on adjacent street

Get rid of your expired, unwanted and unused medications!

Use original prescription containers & use permanent marker to mark out your name and personal information.

Disposal directions available at drop-off site. Only give medications to personnel at drop-off site.

Please be aware that the following items will NOT be accepted:
Illegal drugs
Liquid containers more than 4 ounces
Sharps containers, needles, or syringes
Medical devices, chemicals or other hazardous materials

A community service project in collaboration with the AMA-MSS Community Service Committee and the Medical Student Section at the University of Hawaii School of Medicine
2017 AMA Minority Affairs Section Interim Meeting

How family-centered care helps Hawai’ian health care meet the needs of an extremely diverse patient population

4:30 p.m. | Friday, Nov. 10
Room: Rainbow 3 | Hilton Hawaiian Village

Speaker
Maile Taualii, PhD, MPH
Assistant professor, Native Hawaiian and indigenous health
Hawai’inuiakea, School of Hawaiian Knowledge
University of Hawaii, Manoa

Overview
Hawai’i’s diverse population requires that health care providers be responsive to cultural diversity and reflexive to a patient’s individual needs, all while embracing the Native Hawaiian values of respect, humility, kindness, patience and aloha.

This presentation will focus on research and recent efforts to develop an “‘ohana-centered” model for health care delivery that is rooted in these values. ‘Ohana in its most literal sense means “family.” This work focuses on moving from patient-centered care to ‘ohana-centered care with the goal of assisting patients in receiving not only the best individual care and disease prevention, but also providing advice and assistance in keeping their entire ‘ohana healthy, from their kupuna (elders) to their unborn keiki (children) and everyone in between. The goal of this culturally respectful delivery model is to prevent disease, maintain health, prepare for the next generation and help the kupuna ease gracefully into the time of hala, or the passing from this life into the next.
2017 AMA Advisory Committee on LGBTQ Issues Interim Meeting

Walking the walk: How to navigate LGBTQ community engagement and social justice in medicine

5:30 p.m. | Friday, Nov. 10
Room: Tapa 1 | Hilton Hawaiian Village

The American Medical Association Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Issues invites you to the following special presentation during its Interim Meeting.

Overview
Panelists will share perspectives on medicine and community engagement as a form of social activism to achieve health justice. They will discuss their decades-long practice of medicine through public health and legal crises (e.g., AIDS epidemic, same-gender marriage) in the Hawaiian LGBTQ community and how it led to improved health and wellness today, as well as for future generations.

Moderator
David McEwan, MD
Family medicine
Private practice

Panelists
Robert Bidwell, MD
Adolescent medicine
J.A. Burns School of Medicine
University of Hawai‘i, Mānoa

Jennifer Frank, MD
Family medicine
University Health Services
University of Hawai‘i, Mānoa

Drew Kovach, MD
Family medicine
J.A. Burns School of Medicine
University of Hawai‘i, Mānoa
2017 AMA Senior Physicians Section Interim Meeting

Educational session: “Keeping your brain fit”
Noon–1:30 p.m. | Saturday, Nov. 11
Room 312 | Hawaii Convention Center

The American Medical Association Senior Physicians Section (SPS), the AMA Academic Physicians Section (APS) and the AMA Organized Medical Staff Section (OMSS) invite you to this joint educational program during the 2017 AMA Interim Meeting.

Moderator
Paul H. Wick, MD
Chair, AMA-SPS Governing Council

Speaker
Allan A. Anderson, MD, MMM
Assistant professor, Johns Hopkins School of Medicine; vice president, Dementia Care Practice, Integrace; medical director, Samuel and Alexia Bratton Memory Clinic, The Gardens at Bayleigh Chase, Easton, Md.

Reaction panelist
Jeremy A. Lazarus, MD
Past president, AMA (2012–2013)

It is important for physicians and other clinicians to know the science behind claims for various products and other treatment options. To date, the best evidence supports lifestyle changes to improve cognitive function and possibly prevent dementia, with little data to support other approaches. This presentation will summarize this data and present evidence for physicians to provide to their patients prudent information about ways to “maintain the brain” as their patients age.

Learning objectives
Upon completion of this activity, the physician will be able to:

• Identify the ways our cognitive abilities change with normal aging.
• Describe the potential lifestyle changes that promote optimal brain functioning.
• Recognize the difficulty in translating observational studies to specific recommendations.

Please join us for the AMA-SPS Assembly Meeting where we will discuss AMA House of Delegates business items and future AMA-SPS activities
11:30 a.m.–noon
Saturday, Nov. 11
A light lunch will be offered at 11:30 a.m., first come, first served.

Spread the word! Any physician 65 years of age and above is welcome to attend! Visit ama-assn.org/go/spS to learn more.
The AMAF seeks student input!

As the AMA Foundation shapes their new Leadership Development Institute, we are asking for medical student feedback. What would you like to see in a leadership and mentorship program?

Focus Group Sessions @ 2017 Interim Meeting

Stop by to participate and have some snacks!

Thursday, November 9th 4:00-5:00pm in Hilton Iolani 6-7
Friday, November 10th 8:00-9:00am in Hilton Iolani 3
Sunday, November 11th 8:00-9:00am in Hilton Iolani 3

RSVP to emily.demko@ama-assn.org