AMA Medical Student Section

2018 Interim Meeting
Gaylord National Resort & Convention Center
November 8-10, 2018

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Last updated 10/25/2018

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Agenda and Meeting Information

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Meeting App
Download the meeting app
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Convention Center Information
Gaylord National Resort & Convention Center 201 Waterfront Street National Harbor, MD 20745 (301) 965-4000
Facility map
MSS Assembly seating chart -- available on-site
WiFi access
Network ID: AMAHOD2018 Password: AMAHOD2018

AMA Medical Student Section

2018 Interim Meeting
Gaylord National Resort & Convention Center (National Harbor, MD)
November 8-10, 2018

Business | Education & Programming | Region Events

Thursday, November 8		
10:30 a.m.-7 p.m.	Registration	Maryland Pre-Function Area
3-4 p.m.	Orientation	Potomac Ballroom B
4:30-5:30 p.m.	Student delegate credentialing	Potomac Ballroom B
4:30-5:30 p.m.	Candidate forum	Potomac Ballroom B
5:30-7 p.m.	Assembly opening session	Potomac Ballroom B
7-9 p.m.	Region business meetings	
	Region 1: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Riverview 1
	Region 2: Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin	Potomac 1
	Region 3: Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas	Chesapeake E
	Region 4: Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee	Riverview A
	Region 5: Indiana, Kentucky, Michigan, Ohio, West Virginia	Potomac Ballroom B
	Region 6: Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia	Potomac Ballroom D
	Region 7: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	Potomac 2
Friday, November 9		
7 a.m.-6 p.m.	Registration	Maryland Pre-Function Area
7-8 a.m.	Student delegate credentialing	Potomac Ballroom B
8-9:30 a.m.	Business meeting	Potomac Ballroom B
8:30-9:15 a.m.	Identifying victims of sex trafficking: The role of the physician	Chesapeake G-H

9:30-11:30 a.m.	Region business meetings	
	Region 1: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Chesapeake 3
	Region 2: Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin	Chesapeake 9
	Region 3: Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas	Chesapeake K
	Region 4: Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee	Chesapeake I
	Region 5: Indiana, Kentucky, Michigan, Ohio, West Virginia	Chesapeake 5
	Region 6: Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia	Chesapeake 6
	Region 7: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	Chesapeake L
10 a.m.	First ballot voting begins	
11:30 a.m.-12:15 p.m.	Standing Committee leadership meeting – *current SC members only*	Potomac Ballroom B
12:15-12:45 p.m.	Standing Committee meet & greet – *all MSS members welcome*	Potomac Ballroom B
Noon-8:30 p.m.	AMA Expo and Research Symposium - view event agenda	Exhibit Hall C
12:30-1 p.m.	Student delegate credentialing	Potomac Ballroom B
1-5 p.m.	Business meeting	Potomac Ballroom B
1-2 p.m.	Providing care for child and adolescent refugees	Chesapeake G-H
2-3 p.m.	Health care think tank: Members moving medicine	Magnolia 3
3-3:30 p.m.	The Forgotten Americans: An introduction to US-Mexico border colonias	Chesapeake G-H
3:30-4:15 p.m.	The FDA: What do they do for physicians and patients?	Magnolia 3
4-4:45 p.m.	Opioid rehabilitation and care coordination: What physicians in training need to know	Chesapeake G-H
4:30-5 p.m.	Mergers, acquisitions and partnerships in health care: Why is New York-Presbyterian in the Florida Keys?	Magnolia 3
5-5:45 p.m.	Advocacy in action: Enacting change at a grassroots level	Chesapeake G-H
6-8 p.m.	Region business meetings	
	Region 1: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	Chesapeake I
	Region 2: Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin	Chesapeake K
	Region 3: Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas	Chesapeake L
	Region 4: Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee	Potomac 3
	Region 5: Indiana, Kentucky, Michigan, Ohio, West Virginia	Chesapeake 7-9
	Region 6: Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia	Chesapeake G-H
	Region 7: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	Chesapeake 3
8-8:30 p.m.	Orientation for newly-elected Regional Delegates/Alternate Delegates	Potomac Ballroom B

Saturday, November 10		
7 a.m.-6 p.m.	Registration	Maryland Pre-Function Area
6:30-7 a.m.	Student delegate credentialing	Potomac Ballroom B
8 a.m.	First ballot voting ends	
7:30-8:30 a.m.	Scope of Practice: How the AMA protects physicians' role in providing patient-centric care *Presented by the AMA Sections and Special Groups*	Potomac D
8-10 a.m.	Business meeting	Potomac Ballroom B
8-9 a.m.	Design thinking in healthcare	Potomac 6
8:45-9:45 a.m.	Our turn to serve: How to improve health care for veterans *Presented by the AMA Sections and Special Groups*	Potomac Ballroom D
9-9:30 a.m.	Caring for vulnerable populations: What you can do to support LGBTQ+ youth	Azalea 3
9:30-10 a.m.	Train the trainer: Empowering your community to combat the opioid crisis	Potomac 6
10-11 a.m.	Is there a vaccine for burnout? Building resilience in the medical student community	Chesapeake G
10-11 a.m.	Mind the gap: Improving undocumented patients' access to care *Presented by the AMA Sections and Special Groups*	Potomac Ballroom D
11 a.m.-Noon	Difficult conversations: End of life care	Potomac 6

AMA EXPO

2018 AMA EXPO • 16th annual AMA Research Symposium

Upon arrival to the Gaylord National Resort and Convention Center, please report to the AMA Interim Meeting registration in the Maryland Foyer on the lobby level to checkin and pick up a name badge. A name badge is required for entry in the Exhibit Hall.

Friday, Nov. 9

Noon–2 p.m.	**Poster and podium presentation check-in and set up**	Prince George Exhibit Hall C
1–3 p.m.	**Judge check-in**	Prince George Exhibit Hall C
2–3 p.m.	**Education session**	EXPO stage in Prince George Exhibit Hall C
3–5 p.m.	**Poster presentations**	Prince George Exhibit Hall C
5–6:30 p.m.	**Podium presentations**	EXPO stage in Prince George Exhibit Hall C
7:30–8:30 p.m.	**Networking/announcement of winners**	Prince George Exhibit Hall C

Agenda is subject to change. Notification will be sent directly to the winners at the conclusion of the event.

Judges are welcome to join us in the judge lounge in the Prince George Exhibit Hall C before, during and after the symposium.

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Downloading the App

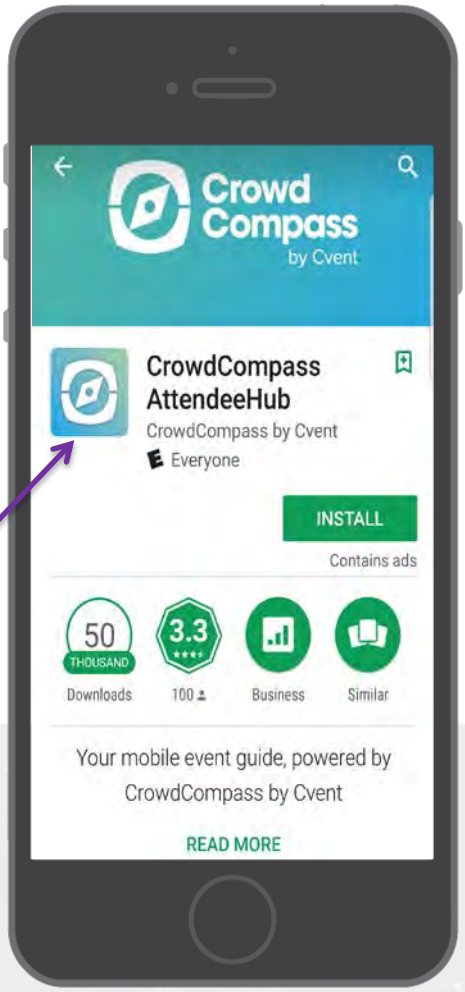
Get the app

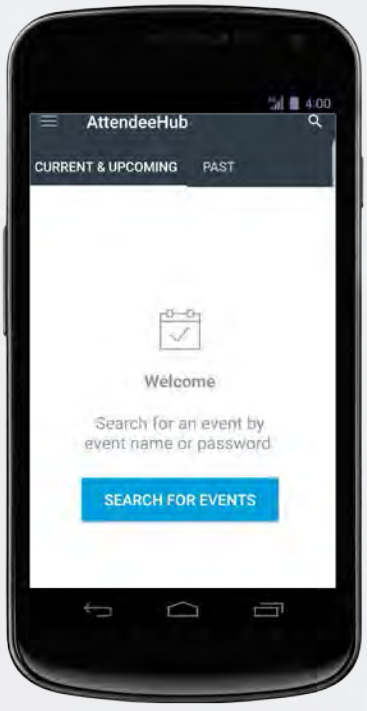
1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here: https://event.crowdcompass.com/ama2018interim**

2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.





Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter AMA 2018 Interim Meeting

2. Open your event. Tap the name of your event to open it.

AMA
AMERICAN MEDICAL ASSOCIATION

The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompass AttedeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/ama2018interim

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2018 Interim Meeting

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

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

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

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

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2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

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

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

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

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

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

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

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

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

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

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

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

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

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

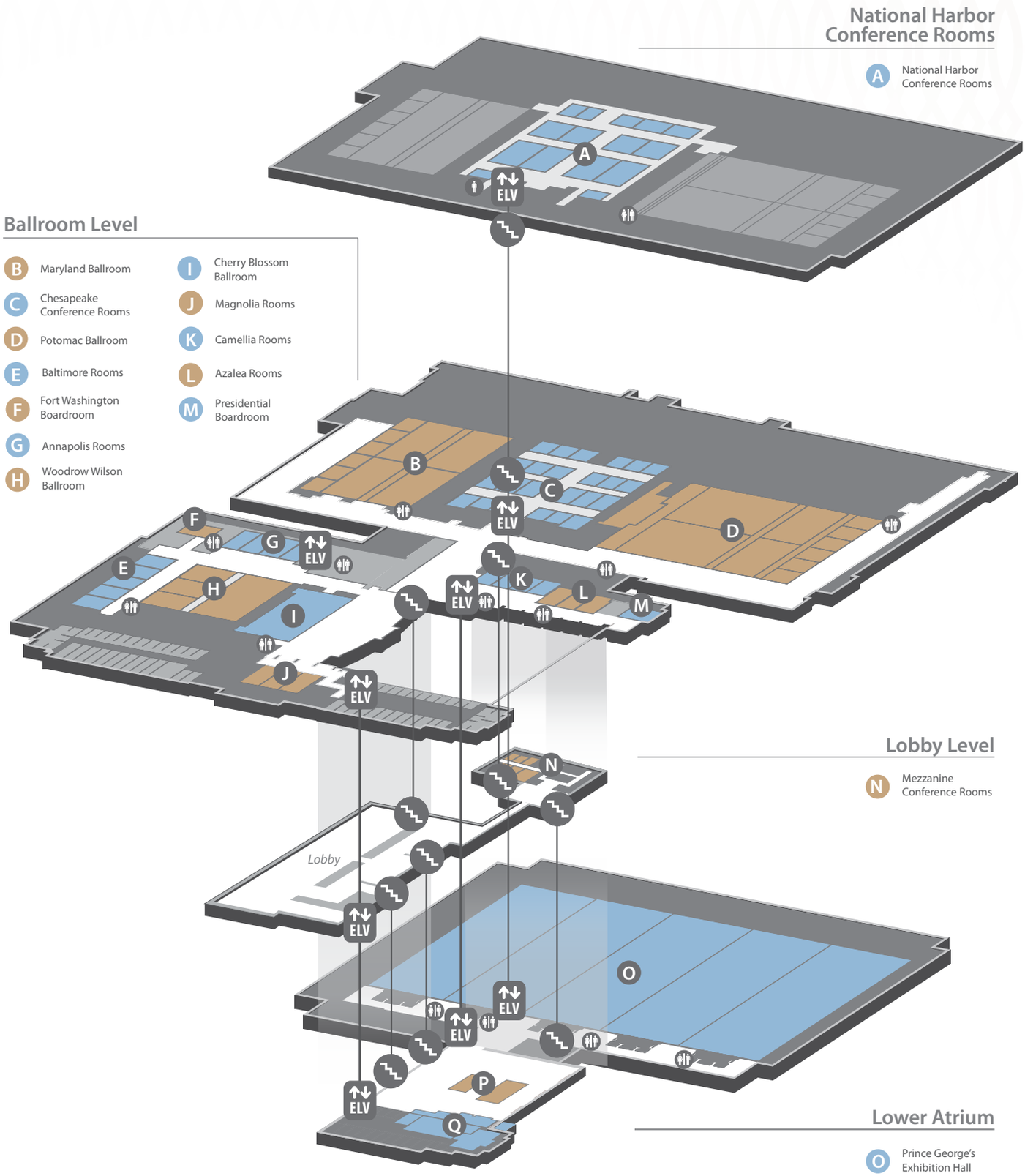
2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

Meeting Space Map



Business

Business Information
Reference Committee report
Fiscal note rubric
Resolution writing guide
Parliamentary procedure
MSS policy highlights from the 2018 AMA Annual Meeting
Resolutions
Resolution 1 - Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents
Resolution 2 - Medical Drone Usage in Rural America
Resolution 3 - Support for Children of Incarcerated Parents
Resolution 4 - Compassionate Release for Incarcerated Patients
Resolution 5 - Inclusion of Pregnant Women in the Secondhand Smoke Driving Ban
Resolution 6 - Promoting Research into the Effects of Net Neutrality on Public Health
Resolution 7 - Opposing Unregulated, Non-Commercial Firearm Manufacturing
Resolution 8 - Support for Housing Modification Policies
Resolution 9 - Support Standardization of Care for Postpartum Hemorrhage
Resolution 10 - Support for the Delegation of Informed Consent Procurement
Resolution 11 - Improving Body Donation Regulation
Resolution 12 - Modernizing Patient Gowning Practices in Healthcare
Resolution 13 - Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program
Resolution 14 - Increasing PrEP Access by Advocating for Generic Entry into the U.S. Marketplace
Resolution 15 - Opposing Office of Refugee Resettlement's Use of Medical/Psychiatric Records for Evidence in Immigration Court
Resolution 16 - Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations

Resolutions (cont.)
Resolution 17 - Supporting Research into the Therapeutic Potential of Psychedelics
Resolution 18 - Opposing Mandated Reporting of People Who Question Their Gender Identity
Resolution 19 - Support for Universal Basic Income Pilot Studies
Resolution 20 - Increasing Transparency in Food Labeling Regarding Food Products Contributing to Metabolic Syndrome
Resolution 21 - Trauma-Informed Care Resources
Resolution 22 - Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
Resolution 23 - Supporting Life Narrative Services in Geriatric Patients
Resolution 24 - Reducing Maternal Tobacco Use During Pregnancy
Resolution 25 - Gun Violence and Mental Illness Stigma in the Media
Resolution 26 - Encouraging Development of Physician Liability Guidelines in Telemedicine
Resolution 27 - Increasing the Availability of Bleeding Control Supplies
Resolution 28 - Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage
Resolution 29 - Understanding Philanthropic Efforts to Address Medical School Tuition
Resolution 30 - Bridging the Gender Pay Gap
Resolution 31 - Advocate to End Child Marriage in the United States
Resolution 32 - Sexual and Gender Minority Populations in Medical Research
Resolution 33 - Encouraging Stocking Epinephrine Auto-Injector Devices at Restaurants
Resolution 34 - Introducing Teach-Back Education into Medical School Curriculum
Resolution 35 - Increasing Access to Trauma-Informed Services within Schools
Resolution 36 - End Punitive Measures for Pregnant Women Who Use Drugs
Resolution 37 - Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
Resolution 38 - Evaluating Medical Service Trips (MSTs) Sponsored by Accredited U.S. Medical Institutions
Resolution 39 - Provision of Longitudinal Medical Care to Babies, Mothers, and Caregivers Impacted by Substance Use and Exposure
Resolution 40 - Eliminating Recommendations to Restrict Dietary Cholesterol and Fat
Resolution 41 - Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals
Resolution 42 - Practice-Based Approach to Resolving Maternal Mortality and Morbidity in Racial Minorities
Resolution 43 - Mandatory Reporting of Sexual Misconduct Allegations to Law Enforcement
Resolution 44 - Addressing Disparities Related to Breast Cancer Differences Between African American Women and Other Women

Resolutions (cont.)
Resolution 45 - Be the Change: Implementing AMA Climate Change Principles through JAMA Paper Consumption Reduction and Green Healthcare Leadership
Resolution 46 - Amendment to H-170.967 and D-60.994 for Inclusion of Comprehensive Sexual Health Education for Incarcerated Juveniles
Resolution 47 - Legalization of Consensual Sex Work
Resolution 48 -Implementing Elective Rotations and Increasing Exposure to Prisons into the Medical Education Curriculum
Resolution 49 - Support The Widespread Distribution of Naloxone Boxes Throughout the Country
Resolution 50 - Equalizing End of Life Care for People with Disabilities
Resolution 51 - Utilizing Food Insecurity Screenings in the Emergency Medical Setting to Identify at Risk Individuals
Resolution 52 - Increasing Education Regarding Transition Planning for Children with Chronic Health Conditions, Not Limited to Those with Developmental Disabilities
Resolution 53 - Public Health Awareness of Adverse Childhood Experiences
Resolution 54 - Access to Healthcare Services Denied by Faith-Based Healthcare Organizations
Resolution 55 - National Guidelines for Guardianship
Resolution 56 - Support for Patient-Centered EHRs
Resolution 57 - Promoting the Implementation of and Education Regarding Teleneurology along the Stroke Belt and other Rural Patient Populations
Resolution 58 - Addressing Medical Data Vulnerabilities in Bluetooth and Other Short-Range Wireless Technologies
Resolution 59 - Removing Sex Designation from the Birth Certificate
Resolution 60 - Enhancing Education and Reducing Advertising of Alcoholic Beverages
Resolution 61 - Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems
Resolution 62 - Advocating for Physician Involvement in FDA User Fee Agreements
Resolution 63 - Protect People Who Use Drugs from Prosecution in the Event of Overdose
Resolution 64 - Augmented Intelligence and Physician Data Science Literacy
Resolution 65 - Support for Requiring Investigations into Deaths of Children in Foster Care
Resolution 66 - Acknowledging Disparities in Healthcare Access Among Seasonal Farmworkers in the United States
Resolution 67 - Oppose Requirements of Hormonal Treatments for Athletes
Resolution 68 - Prevent Discriminatory Increases in Insurance Cost for Patients Who Use HIV Pre-Exposure Prophylaxis (PrEP)
Resolution 69 - Enhance Protections for Patients Seeking Help for Pedophilic Urges and the Physicians Treating Them

Reports
MSS Governing Council Report A - Policy Sunset Report for 2013 AMA-MSS Policies
MSS Governing Council Report B - Pilot Implementation of the 2018 Resolution Task Force Recommendations Update
MSS Committee on Medical Education Report A - Requiring Blinded Review of Medical Student Performance
MSS Committee on LGBTQ+ Issues Report A - Gender and LGBTQ+ Discrimination in Income
MSS Committee on LGBTQ+ Issues and Minority Issue Committee Joint Report A - Recognizing LGBTQ+ Individuals as Underrepresented in Medicine
MSS Committee on Health Information Technology Report A - Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication
MSS Committee on Health Information Technology and Committee on Economics and Quality in Medicine Joint Report A - Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized Technology
MSS Committee on Economics and Quality in Medicine Report A - Increased Affordability and Access to Hearing Aids
MSS Committee on Global and Public Health Report A - Adverse Impacts of Delaying the Implementation of Public Health Regulations

Reference Committee Report

The Medical Student Section again utilized a completely Virtual Reference Committee (VRC) for the 2018 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 a 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 Thursday, November 1, 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.

Visit the MSS meeting documents webpage to download the Reference Committee report: https://www.ama-assn.org/about/mss-meeting-documents

AMA-MSS Fiscal Note Rubric

	Expertise Available	No. Of Departments Involved	Timeline Requirement	Does Resolution Require Financial Resources?
Minimal (1pt)	Knowledge is readily available	MSS Only	A month or less	Does not require funding
Moderate (2pt)	Requires some research	2-4	Multiple months	Requires absorbable funding
Significant (3pt)	Requires dedicated research	5+	Over a year	Requires dedicated funding

Point Range	
Minimal	4-6
Moderate	6-10
Significant	10-12
+/- 1 for alignment*	

*Alignment point dependent on alignment with strategic focus areas and IPO's

AMA Medical Student Section I-18 Resolution Guide

The AMA-MSS Resolution Guide serves as a resource to help you craft and submit a resolution. Resolution authors are required to complete the tasks described below. Resolutions will not be considered "received" until all required tasks indicated in the Draft Submission Checklist and Final Submission Checklist have been completed.

Questions? Please contact your AMA-MSS Section Delegates, Joy Lee and Dan Pfeifle, or the AMA-MSS Policy Analyst, Hannah Handal.

Dates and Deadlines* for Resolution Authors
MSS Interim Meeting 2018
**All deadlines expire at 11:59 PM PST except for Open Forum Close time & VRC Open/Close time*

August 21st (Tues)*	Deadline to post ideas on MSS Open Forum **at 5:00 PM PST** Deadline for authors to share ideas with Region Delegation Chair
Sept. 2nd (Sun)	**Draft resolutions due** – must be uploaded along with the I-18 Draft Submission Checklist using the I-18 Resolution Draft Submission Form
Sept. 9th (Sun)	Preliminary scoring and comments on draft resolutions released to authors
Sept. 23rd (Sun)	**Final resolutions due** – must be uploaded along with the Final Submission Checklist and a copy of the Draft Submission checklist using the I-18 Resolution Final Submission Form Authors to respond via email to comments by primary reviewer
Oct 4th (Thurs)*	Virtual Reference Committee (VRC) Opens **at 5:00 PM PST**
Oct 19th (Fri)*	Virtual Reference Committee (VRC) Closes **at 5:00 PM PST**
Nov. 1st (Thurs)	Reference Committee Report Released
Nov. 8-10th	2018 National Medical Student Annual Meeting

Region Delegation Chairs

Region 1- Adam Panzer, ama.mss.region1.delegation@gmail.com

Region 2- Michael Rigby, mrigby@wisc.edu

Region 3- Luis Seija, lseija@medicine.tamhsc.edu

Region 4- Jessica Walsh O'Sullivan, jwalsho@knights.ucf.edu

Region 5- Hari Iyer, hiyer@neomed.edu

Region 6- Aakash Sheth, as2140@njms.rutgers.edu

Region 7- Devin Bageac, dbageac@uchc.edu

Researching Your Resolution

1) Authors must ensure that an MSS resolution is the best means to accomplish their goals. The following are common examples of issues that are NOT best addressed through an MSS resolution:

   The resolution addresses an issue that could be resolved by the AMA-MSS Governing Council, specifically by submitting a GC Action Item request.

   The resolution addresses an issue that the AMA has already spoken to by releasing a statement based upon adopted policy.

   The resolution addresses a medical school-specific issue that would be more appropriately addressed by medical school faculty or administration.

   The resolution addresses a specialty-specific issue that would be more appropriately addressed by the relevant medical specialty society or state medical society.

   The resolution addresses an issue that is already sufficiently covered by existing AMA Policy or existing AMA-MSS Policy.

2) Resolutions that succeed in the MSS are well-researched and novel, and add value to the policy compendiums of the AMA or AMA-MSS. Authors must understand what has been attempted and accomplished in the past in order to produce strong resolutions for the future.

   Review the AMA Strategic Focus Areas to understand the priority issues for our organization. These suggestions can be used to guide resolution topics. (See scoring rubric below).

   Review existing AMA Policy and existing AMA-MSS Policy.

   Review the Summary of Actions for the most recent MSS Assembly meeting and the Proceedings for actions from all past MSS meetings for examples of what policy proposals have and have not been successful in its Assembly.

Writing Your Resolution

1) Use the Resolution Template and Formatting Guide.

2) For **external resolutions** (external resolutions call for the AMA to act, internal resolutions call for the AMA-MSS to act), authors should understand that there is an increased burden to do their due diligence in research, soliciting appropriate feedback and making appropriate contacts that is more rigorous than for internal resolutions. Authors of external resolutions should ensure that their topic is appropriate for external submission, which includes alignment with the MSS Internal Policy Objectives as well as the AMA Strategic Focus Areas.

3) For **external resolutions**, authors should be aware that if their item should pass, it will not be brought forward to the AMA House of Delegates (HOD) until the following national meeting. However, authors must be prepared to complete the following:

   a. Sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly.
   b. Work with the AMA-MSS Delegates in advance of the following national meeting in order to help with the passage of their item, including submitting written testimony in support of the item.

4) For external resolutions that call for immediate forwarding to the House of Delegates (HOD) following the same MSS meeting at which they are passed, authors must be aware that:

   a. Only in rare cases are resolutions forwarded immediately to the HOD.
   b. There must be unusual circumstances deserving of immediate consideration by the HOD.
   c. The MSS Section Delegates must be contacted regarding the author's intentions well in advance of the actual meeting.
   d. Authors must submit written testimony to the MSS Section Delegates for submission to the HOD.
   e. Authors must attend the MSS caucus on Saturday afternoon/evening in order to help with strategy for the passage of their resolution.

5) Note about withdrawal of resolutions: All submitted final resolutions will become the business of the MSS Assembly on October 3rd at 11:59 PM PST. If desired, primary authors will have the opportunity to withdraw their resolutions before this deadline by contacting the Section Delegates.

   a. After this deadline, any author wishing to withdraw their resolution must make a motion at the AMA-MSS Assembly. An Assembly vote on the motion will decide whether the resolution can be withdrawn.

MSS Interim Meeting 2018 Resolution Scoring Rubric

Authorship (5 points)
This will be assigned by the MSS Section Delegates. Was this resolution authored on behalf of an entire School Section (3 points), State (4 points), or Region (5 points)? Otherwise, 0 points are awarded.

Clarity (10 points)
Are the Whereas clauses succinctly stated and do they clearly support the requested action of the Resolved clauses? Do the Whereas clauses create a logical, coherent argument flowing naturally to support the Resolved clauses? Do none, some, or all of the Whereas clauses support the Resolved clauses? Do any Whereas clauses leave you with questions about the issue or about the argument?

Research (30 points)
How many total references do the authors use to support their argument, and are they from appropriate authorities on the subject matter? Are none, some, or all of the references from trustworthy, high quality, evidence-based sources (e.g. peer- reviewed journals, respected news sources)? Are none, some, or all from the past 5 years? Are none, some, or all of the factual assertions in the Whereas clauses supported by sufficient evidence?

Scope (10 points)
Does this resolution address a new, broad principle that will be applicable to multiple issues OR Does it address a specific, current, actionable and timely issue?

Feasibility (15 points)
Is the resolution feasible, appropriate, and within the general scope of issues for the AMA (external) or AMA-MSS (internal) to address?

> **Fiscal Note (considered under Feasibility)**
> Is the fiscal note concerning? Did the authors amend language to decrease the fiscal note? (Please see Fiscal Note Rubric for reference.)

Novelty (15 points)
Does this resolution address a subject matter largely neglected by current policy; add in a valuable way to existing policy; or depart from or oppose current AMA policy or AMA-MSS policy?

Focus (10 points)
Do the Resolved clauses address one or more principles of the MSS' Internal Policy Objectives (IPOs) and/or the AMA's Strategic Focus Areas?

> **MSS Internal Policy Objectives (IPOs):** (1) Pursuing innovative mechanisms to improve medical student wellness and mitigate burnout; (2) Cultivating the delivery of equitable healthcare to diverse patient populations in a dynamic environment, including via the promotion of diversity within the medical profession; and (3) Addressing emergent public health threats with impactful and evidence-based solutions.
>
> **AMA Strategic Focus Areas:** (a) Creating thriving physician practices, (b) Creating the medical school of the future, (c) Improving health outcomes.

Response to Feedback (5 points)
Did the authors respond to scoring and feedback in a way that demonstrated their appreciation for the critiques? For full credit, authors need not necessarily change their resolution, but their responses to feedback must indicate that they have thought through and anticipated objections to their resolution.

Scoring Rubric

Authorship* (5 points)	**0**	**3** (School Section)	**4** (State)	**5** (Region)	
Clarity (10 points)	**0** (Whereas clauses do not support Resolved clauses; difficult to follow argument)	**5** (Some arguments are missing to support the Resolved clauses; argument is unclear at times)	**10** (Whereas clauses clearly support the Resolved clauses; argument clear and logical)		
Research (30 points)	**0** (None of the Whereas clauses are supported by recent, appropriate sources)	**5-10** (Less than half to few whereas clauses are supported by recent, appropriate sources)	**15** (Half of the Whereas clauses are supported by recent, appropriate sources)	**20-25** (Most to nearly all Whereas clauses have sufficient, appropriately sourced evidence)	**30** (All of the Whereas clauses are supported by recent, appropriate sources)
Scope (10 points)	**0** (too specific, not timely or actionable)	**5** (specific, but questionably timeliness or actionability)	**10** (broad in scope OR specific, timely and actionable)		
Feasibility (15 points)	**0** (likely infeasible and clearly not within AMA or MSS purview; fiscal note concerning)	**5** (questionably feasible, and unlikely to be within AMA or MSS purview; fiscal note concerning)	**10** (likely within purview of AMA or MSS, questionably feasible; fiscal note not concerning)	**15** (definitely feasible and clearly within purview of AMA or MSS; fiscal note not concerning)	
Novelty (15 points)	**0** (completely covered by existing policy)	**5** (largely covered by existing policy)	**10** (less significant change to existing policy)	**15** (new subject matter or significant departure from existing policy)	
Focus (10 points)	**0** (does not address any IPO or Strategic Focus Area)	**3** (loosely addresses Strategic Focus Area, does not address any IPO)	**5** (loosely addresses IPO or Strategic Focus Area)	**8** (clearly addresses Strategic Focus Area)	**10** (clearly addresses IPO +/- Strategic Focus Area)
Response to feedback* (5 points)	**0** (authors did not respond to scoring and feedback appropriately)	**5** (authors responded to scoring and feedback appropriately)			

* These rubric areas are assessed by the Section Delegates.

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

BASIC RULES GOVERNING MOTIONS

Order of precedence [1]	*Can interrupt?*	*Requires a second?*	*Debatable?*	*Amendable?*	*Vote required?*	*Applies to what other motions?*	*Can have what other motions applied to it?* [5]	*Renewable?*
PRIVILEGED MOTIONS								
1. Adjourn	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, close debate, limit debate	Yes
2. Recess	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, close debate, limit debate	Yes[6]
3. Question of privilege	Yes	No	No	No	None	None	None	Yes
SUBSIDIARY MOTIONS								
4. Table	No	Yes	No	No	2/3	Main motion	None	No
5. Close debate	No	Yes	No	No	2/3	Debatable motions	None	Yes
6. Limit or extend debate	No	Yes	Yes[2]	Yes[2]	2/3	Debatable motions	Amend, close debate	Yes[6]
7. Postpone to a certain time	No	Yes	Yes[2]	Yes[2]	Majority	Main motion	Amend, close debate, limit debate	Yes[6]
8. Refer to committee	No	Yes	Yes[2]	Yes[2]	Majority	Main motion	Amend, close debate, limit debate	Yes[6]
9. Amend	No	Yes	Yes[3]	Yes	Majority	Rewordable motions	Amend, close debate, limit debate	No[6]
MAIN MOTIONS								
10. (a) The main motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
(b) Specific main motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a previous action	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Recall from committee	No	Yes	Yes[2]	No	Majority	Referred main motion	Close debate, limit debate	No
Reconsider	Yes[4]	Yes	Yes[2]	No	Majority	Vote on main motion	Close debate, limit debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted main motion	Subsidiary, except amend	No

INCIDENTAL MOTIONS

No order of precedence	*Can interrupt?*	*Requires a second?*	*Debatable?*	*Amendable?*	*Vote required?*	*Applies to what other motions?*	*Can have what other motions applied to it?* [5]	*Renewable?*
MOTIONS								
Appeal	Yes	Yes	Yes	No	Majority[7]	Ruling of chair	Close debate, limit debate	No
Suspend the rules	No	Yes	No	No	2/3	Procedural rules	None	Yes
Consider informally	No	Yes	No	No	Majority	Main motion or subject	None	Yes
REQUESTS								
Point of order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a motion	Yes	No	No	No	None[8]	All motions	None	No
Division of question	No	No	No	No	None[8]	Main motion	None	No
Division of assembly	Yes	No	No	No	None[8]	Indecisive vote	None	No

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

[2] Restricted.

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

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

[5] Withdraw may be applied to all motions.

[6] Renewable at the discretion of the presiding officer.

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

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

2018 AMA Annual Meeting -- MSS Policy Highlights

Presented by Daniel Pereira and Adam Darwiche
On behalf of the MSS Committee on Legislation and Advocacy

At 2018 AMA Annual Meeting in Chicago, Illinois, the Medical Student Section (MSS) brought over 30 resolutions to the AMA House of Delegates. Here are a few of the resolutions, the action that the House took on them, and what they mean.

FMLA EQUIVALENCE
HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-270.951

As a result of the Family and Medical Leave Act, eligible employees of covered employers are able to take unpaid leave for family and medical reasons with continued group health insurance coverage and without fear of losing their jobs. The adopted policy states that the AMA will advocate for the FMLA to ensure inclusion not just of those related to the employee by blood, but also those "whose close association with the employee is the equivalent of a family relationship." Thus, this policy expands the valid opportunities for eligible employees to have unpaid, protected time off to care for a loved one.

PATIENT-REPORTED OUTCOMES IN GENDER CONFIRMATION SURGERY
HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-460.893

There is still a paucity of evidence-based protocols and established research seeking to provide guidelines for patient selection, surgical management, post-surgical management, and long term outcomes in gender confirmation surgery. The adopted policy states that the AMA will support such initiatives, research, and standardized tools to further evidence-based care for patients undergoing gender confirmation surgery.

DECREASING SEX AND GENDER DISPARITIES IN HEALTH OUTCOMES
HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-410.946

The adopted policy encourages usage of "decision support tools" in order to reduce gender and sex disparities that result in variable outcomes. However, in clinical circumstances where pathophysiological and physiological differences exist between sexes, the usage of "decision support tools" should be used to standardized care across sex and gender differences.

ENDING MONEY BAIL TO DECREASE BURDEN ON LOWER INCOME COMMUNITIES
HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-80.993

Posting bail is a common practice for individuals awaiting court proceedings to avoid detention or jail time in the interim. However, for obvious reasons, this measure is vastly more available to individuals in a higher income bracket. Conversely, lower income communities are unable to post money bail and therefore undergo pre-trial detention at a higher volume. Research has

shown that pre-trial detention results in worse health outcomes regardless of trial outcome. As such, this policy encourages the AMA to recognize the adverse health outcomes of pre-trial detention and supports measures that provide alternative choices from money bail for individuals charged with non-violent crimes.

CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES
HOUSE ACTION: ADOPTED AS FOLLOWS See Policy H-525.974
Currently, the Internal Revenue Service (IRS) accepts deductions from a list of very specific line items it deems as "medical necessities." Most widely-used feminine hygiene products are not included in the list, despite the fact that these hygiene products are necessary to prevent infection or other comorbidities, as well as to promote general hygiene. Furthermore, these products are used frequently and can consume a significant portion of a person's disposable income, making a tax deduction both warranted and beneficial. The second part of this policy also advocates for "the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge the appropriate type and quantity of feminine hygiene products, including tampons for their needs".

OPPOSITION TO REGULATIONS THAT PENALIZE IMMIGRANTS FOR ACCESSING HEALTH CARE SERVICES
HOUSE ACTION: ADOPTED AS FOLLOWS See Policies H-20.901 and D-440.927
Non-cash public benefits like Medicaid, CHIP, WIC, SNAP, and others are widely used by many immigrants in the United States to maintain proper health care despite their undocumented status. However, recent changes threaten to remove these benefits from the hands of immigrants by enforcing policies that would penalize them for accessing these health care services. This policy allows the AMA to oppose any measure intended to deter or punish immigrants from attaining these necessary health care resources. Additionally, this policy amended standing AMA policy to reaffirm the AMA's support for the 1990 public charge, encourage the U.S. Public Health Service to be the sole arbiter of immigrant's access to care, and oppose exclusion of immigrants in travel based on HIV status.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 1
(I-18)

Introduced by: Region 1, Region 4, Region 5; Faith Crittenden, University of Connecticut School of Medicine

Subject: Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Neonatal abstinence syndrome (NAS) is defined as a postnatal withdrawal syndrome often occurring in infants exposed to opioids in-utero;[1] and

Whereas, The prevalence of opioid use disorder in pregnant women quadrupled from 1994 to 2014 to 6.5 per 1,000 births;[2] and

Whereas, The prevalence of NAS between 2000 to 2012 increased to 6.0 per 1,000 births, a five-fold increase, and in 2016 was found to be as high as 20 per 1,000 births in 23 hospitals;[1] and

Whereas, Current treatment focuses on both pharmacologic care, most commonly the prescription of morphine,[3] and non-pharmacologic care, focused on practices such as swaddling, frequent feeds, and skin-to-skin care (consisting of placing the child on the parents bare chest), with most patients being admitted to a neonatal intensive care unit (NICU); and

Whereas, The American Academy of Pediatrics (AAP) recommends that patients with NAS be treated via non-pharmacologic care in less severe cases;[4] and

Whereas, The cost of treating patients with NAS was found to have surged from $61 million in 2003 to $316 million in 2012[5] with a mean length of stay (LOS) in the NICU of 16.57 days, occupying 4% of US NICU beds;[6] and

Whereas, Patients with NAS are hyperarousable[7] with altered sleep/wake states and thus require a dark, quiet environment and minimal stimulation; and

Whereas, The flashing lights and alarms in a NICU do not reflect the recommended environment for patients with NAS,[8] and as such patients with NAS placed in NICUs have been found to experience more severe withdrawal, have longer LOS, and increased pharmacotherapy compared to those who were not;[9] and

Whereas, Rooming-in, where patients with NAS are admitted to in-patient rooms with their parents or legal guardians for the duration of their stay, is an alternative to NICU admission; and
Whereas, Mothers of patients with NAS are often treated at prenatal clinics for substance use disorder, where they also receive education about NAS[10], and continue to receive treatment while rooming-in with their child;[11] and

Whereas, Rooming-in was found to be associated with a reduction between 20-60% in patients requiring pharmacological treatment,[1] shortened LOS at Dartmouth Hitchcock Medical Center from 17 days to an average of 12 days,[11] and lowered cost by 75% without a significant difference in readmission rates or adverse in-hospital events;[9,11,12] and

Whereas, Rooming-in has been noted to have the additional benefits of increasing parental involvement[12] and breastfeeding;[9] and

Whereas, The AAP Committee on Fetus and Newborn found that rooming-in provides more security for healthy term newborns, increases supervised maternal-newborn interactions, and more opportunities for hospital staff to empower parents to care for their infants;[13] and

Whereas, Maximum parental presence (100%) was associated with a 9 day shorter LOS and 8 fewer days of infant opioid therapy at Boston Medical Center as well as fewer days of infant opioid therapy and reduced mean NAS score after adjusting for breastfeeding;[14] and

Whereas, bonding and attachment aided by the release of oxytocin during breastfeeding may protect the mother against addiction relapse and stress[15] and breastfeeding can prevent or reduce complications of NAS so infants demonstrate lower NAS scores, need less pharmacological treatment, and once again have a shorter LOS;[16,17] therefore, be it

RESOLVED, That our AMA support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health permits, through the implementation of rooming-in programs; and be it further

RESOLVED, That our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome.

Fiscal note: Minimal, 6

Date received: 09/23/18

References:

1. Wachman, E. *et al.* Neonatal Abstinence Syndrome: Advances in Diagnosis and Treatment. *JAMA*. 2018;319(13):1362-1374.
2. Haight, S. *et al.* Opioid Use Disorder Documentation at Delivery Hospitalization - United States, 1994-2014. *Morbidity and Mortality Weekly Report*. 2018;67(31):845-849.
3. Kocherlakota, P. Neonatal Abstinence Syndrome. *Pediatrics*. 2014;134(2):e547-e561.
4. Hudak, M.L. *et al.* Neonatal Drug Withdrawal. *Pediatrics.* 2012;129(2):e540-e560.
5. Corr, T. and Hollenbeak, C. The economic burden of Neonatal Abstinence Syndrome in the United States. *Addiction*. 2017;112(9):1590-1599.
6. Tolia, V. *et al.* Increasing incidence of the neonatal abstinence syndrome in U.S. neonatal ICUs. *New England Journal of Medicine*. 2015;372(22):2118-2126.
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8. Grossman, M. *et al.* An Initiative to Improve the Quality of Care for Infants With Neonatal Abstinence Syndrome. *Pediatrics*. 2017;139(6):e20163360.
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10. Newman, A. *et al.* Rooming-In for infants of opioid-dependent mothers. *Canadian Family Physician*. 2015;61(12):e555-e561.
11. Holmes, A. *et al.* Rooming-In to Treat Neonatal Abstinence Syndrome: Improved Family-Centered Care at Lower Cost. *Pediatrics*. 2016;137(6):e20152929.
12. Loudin, S. *et al.* A management strategy that reduces NICU admissions and increases charges from the front line of the neonatal abstinence syndrome epidemic. *Journal of Perinatology*. 2017;37:1108-1111.
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15. Tops M, et al. Why social attachment and oxytocin protect against addiction and stress: insights from the dynamics between ventral and dorsal corticostriatal systems. *Pharmacol Biochem Behav. 2014;119:39-48.*
16. Isemann B, et al. Maternal and neonatal factors impacting response to methadone therapy in infants treated for neonatal abstinence syndrome. *J Perinatol*. 2011;31(1):25-29.
17. Well-Strand GK, et al. Breastfeeding reduces the need for withdrawal treatment in opioid-exposed infants. *Acta Paediatr*. 2013;102(11):1060-1066.

RELEVANT AMA AND AMA-MSS POLICY:

Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970

It is the policy of the AMA (1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;

(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same. Res. 131, A-90

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care. CSA Rep. G, A-92; Modified: Alt. Res. 507, A-16; Modified: Res 906, I-17

Drug Abuse in the United States - the Next Generation H-95.976
Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;
(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;

(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. BOT Rep. Y, I-89

Opioid Abuse in Breastfeeding Mothers 100.017MSS

AMA-MSS (1) will ask that our AMA Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines; and (2) will ask that our AMA amend by addition existing AMA policy H-420.962 Perinatal Addiction–Issues in Care and Prevention to read as follows:

Perinatal Addiction – Issues in Care and Prevention H-420.962

Our AMA:

(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability;

(2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible;

(3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long- term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children;

(4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and

(5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and

breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
(MSS Res 07, A-17)

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 2
(I-18)

Introduced by: Region 4; Student National Medical Association (SNMA)

Subject: Medical Drone Usage in Rural America

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Rural hospitals and areas have a shortage of life-saving medical supplies and equipment;[1,2] and

Whereas, 57% of hospitals in the USA reported a shortage of blood supply with some rural hospitals receiving blood only twice per week;[2,3] and

Whereas, Blood delivery via drones has been proven to be highly effective in international rural settings;[4,5] and

Whereas, Drones could be used to deliver blood to rural areas in the USA decreasing time to receive treatment and improving prognosis;[1] and

Whereas, Drones could also be used to deliver time-sensitive antidotes, poorly stocked medical supplies, and life-saving equipment to isolated areas with no hospital in range;[1] and

Whereas, According to the American Heart Association, every minute a victim of cardiac arrest waits to receive defibrillation, odds of survival decrease by seven to ten percent;[5] and

Whereas, Drones can save an average of 16 minutes for defibrillator delivery time increasing chance of survival;[5,6] and

Whereas, Current AMA policy (H-465.994, Improving Rural Health Care) (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, and (2) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public; and

Whereas, Current AMA policy (G-615.035, Technology and the Practice of Medicine) encourages the collaboration of AMA Councils and working groups on matters of new and developing technology, particularly … telemedicine; therefore, be it

RESOLVED, That our AMA-MSS include promotion of research on the use of medical drones in rural areas to serve poorly stocked medical supplies and equipment such as blood, defibrillators, and antidotes to medically underserved areas as a form of telemedicine.

Fiscal note: Minimal, 5

Date received: 09/23/2018

References:

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4. These American Drones Are Saving Lives in Rwanda. TIME.com. http://time.com/rwanda-drones-zipline/. Published 2018. Accessed September 1, 2018.
5. How Drones Are Aiding Humanitarian Efforts In Rural Communities. Forbes. https://www.forbes.com/sites/delltechnologies/2017/12/22/how-drones-are-aiding-humanitarian-efforts-in-rural-communities/#7a2d77bd7c14. Published January 5, 2018. Accessed September 1, 2018.
6. Pulver A, Wei R, Mann. C. Locating AED Enabled Medical Drones to Enhance Cardiac Arrest Response Times. Prehospital emergency care: official journal of the National Association of EMS Physicians and the National Association of State EMS Directors. 2016;20(3):378-389.

RELEVANT AMA AND AMA-MSS POLICY:

Improving Rural Health Care H-465.994
The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.

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.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 3
(I-18)

Introduced by: Region 1

Subject: Support for Children of Incarcerated Parents

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The United States has the highest rate of incarceration in the world[1] with 2,162,400 incarcerated persons as of year-end 2016[2]; and

Whereas, Despite the U.S. population being 60.7% White non-Hispanic, 13.4% Black/African American, and 18.1% Hispanic[3], as of 2016 year-end, the imprisoned population in federal and state prisons not including local jails was 30.1% White non-Hispanic, 33.3% Black, and 23.3% Hispanic[4]; and

Whereas, An estimated 2.7 million children in the United States have at least one parent incarcerated at any given time and approximately 10 million children have experienced parental incarceration at some point in their lives[5]; and

Whereas, As a result of parental incarceration, worse health outcomes disproportionately impact minorities with 1 in 9 children with incarcerated parents being African American, 1 in 18 being Hispanic, and 1 in 57 being White[5]; and

Whereas, Parental incarceration has been found to be a strong risk factor for long-lasting psychopathology in children, including antisocial behaviors[6] and health problems including depression, posttraumatic stress disorder, anxiety, hyperlipidemia, asthma, migraines, HIV/AIDS, and overall fair/poor health[7]; and

Whereas, Additionally, an association has been found between parental incarceration and forgone healthcare, higher ED utilization, obesogenic behaviors, high risk sexual behaviors, and substance use and abuse including increased risk of prescription drug abuse[8] with one study reporting a 25-55% increased risk of prescription pain reliever misuse among children of incarcerated parents[9]; and

Whereas, The number of adverse childhood event (ACE) exposures has been shown to be directly correlated to increased likelihoods of specific negative health outcomes such as coronary disease, diabetes, asthma, disability, and mental distress[10]; and

Whereas, Children with incarcerated parents are more likely to experience additional ACEs, nearly 5x as many as their counterparts without incarcerated parents[11], such as but not limited to financial hardship and exposure to drug and alcohol abuse[12]; and

Whereas, Early childhood interventions including the development of high quality programs providing accessible resources for education and for supporting parent-child relationships improve health outcomes and health behaviors particularly in at-risk youth[13]; and

Whereas, Providing children with coping strategies and additional emotional resources, such as mentors, trained teachers, skilled counselors, and strong foster families can help children feel comforted and secure throughout a parent's incarceration[14]; and

Whereas, Child interactions with incarcerated parents have been shown to affect attachment styles with both their parent as well as their interim caregiver[15]; and

Whereas, Established intervention programs aimed at improving the interactions between children and their incarcerated parents, such as the Family Connections which allows the parents to record a DVD of them reading their child a book[16] and the Strengthening Families Program providing incarcerated parents, their children, and the child's interim caregiver with in-person visits, individual counseling and family skill sessions[17] have shown to increase student performance and interest in school, improve familial functioning, and improve parental mental health; and

Whereas, Still other studies have shown that increased telephone and written letter contact between children and their incarcerated parents resulted in fewer child behavioral problems[18] and another study showed children who had more in-person contact with their incarcerated parents improved mental health by reducing feelings of anger and alienation toward their parent compared to children who had no contact[19]; and

Whereas, Established intervention programs identify arranging visits and the privacy of the parent-child interactions, the need for more interaction with case workers, and the lack of sufficient training for program providers as barriers to providing better services[20]; and

Whereas, Plexiglas visitations as opposed to other types of contact have been found to contribute more to fear/sadness attachment styles towards parents during interactions compared to other interaction means as well as prolonged anxiety after the interaction[15]; and

Whereas, The AMA policy H-430.990 has previously supported further research on and implementation of programs to promote maternal/child bonding among incarcerated mothers[21]; and

Whereas,The House of Representatives has introduced a resolution (H.Res.623) that recognizes the importance of providing services to children of incarcerated parents[22]; and

Whereas, The Senate has received resolution H.Res.5682 passed by the House of Representatives that requires that federal prisoners to be placed within 500 miles of their families in an attempt to improve parental-child contact with the aim of reducing recidivism[23]; therefore be it

RESOLVED, That our AMA support legislation and initiatives that provide resources and support for children of incarcerated parents including, but not limited to, access to counseling and mentorship services for children of incarcerated parents and their interim caregivers, resources to improve visitation and other methods of parental contact, and improved access to healthcare resources such as primary care services.

Fiscal note: Significant, 10

Date received: 09/23/18

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RELEVANT AMA POLICY:

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.

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.

Long-Term Care Residents With Criminal Backgrounds H-280.948
1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.
2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.

3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.
4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Improving Pediatric Mental Health Screening H-345.977
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Drug Abuse in the United States - Strategies for Prevention H-95.978
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical **strategies** that are most effective in ameliorating risk factors.
(2) Urges the Center **for** Substance Abuse **Prevention** to continue to support community-based **prevention strategies** which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of drug and alcohol abuse **prevention** and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" **prevention** approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and **prevention**-oriented messages about the effects of drug and alcohol abuse.
(4) Supports the development of advanced educational programs to produce qualified **prevention** specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.

(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of **prevention** activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on **prevention** and eradication of alcohol and drug abuse.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 4
(I-18)

Introduced by: Region 7; Alina Spiegel, Ellie Burton, Meghana Jami, Laura Pugh, and John Gatti, Johns Hopkins University School of Medicine; Rachel Ekaireb, UCSF School of Medicine; Sarah Mae Smith, UC Irvine School of Medicine

Subject: Compassionate Release for Incarcerated Patients

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Compassionate release, sometimes called “early medical parole” or “early medical release” describes a range of policies that allow incarcerated individuals who have a serious or debilitating medical condition and/or advanced age to secure early release from an existing sentence;[1,2] and

Whereas, The aging incarcerated population is increasing exponentially, with the number of state prisoners age 55 or older having more than quadrupled from 6300 to 25,700 between 1993 and 2013;[3] and

Whereas, Aging incarcerated individuals in state correctional facilities have medical costs three to nine times higher than their younger incarcerated counterparts as a result of their elevated susceptibility to chronic and age-associated conditions;[4] and

Whereas, since 2005, annual deaths in prisons and jails have approached 4,000 with cancer and heart disease being the two leading causes of death, both of which are associated with advanced age;[5] and

Whereas, Aging incarcerated individuals require medically appropriate accommodations, including ramps, lower bunks, handicapped-accessible cells, and assistance with feeding that many facilities are unable to provide due to old infrastructure, overcrowding, and lack of appropriate training for staff;[4,6,7] and

Whereas, Few facilities have special units for incarcerated individuals with cognitive impairments, and often, they must rely on fellow incarcerated people for support in the general incarcerated population;[4] and

Whereas, Incarcerated people have a constitutional right to adequate medical care;[8] and

Whereas, Existing AMA policy affirms that it believes in “preserving dignity and self respect of all individuals at all ages” (H-25.997); and

Whereas, Although 49 states and the District of Columbia have laws that permit compassionate release, few incarcerated individuals are able to benefit from this and receive early release due to the fact that these state laws are inconsistent, confusing, do not delineate a clear process, or contain overly strict eligibility criteria;[2] and

Whereas, Arizona requires compassionate release applicants to be facing “imminent death,” but has three different definitions of “imminent death” among Department of Corrections and Board of Executive Clemency documents;[2] and

Whereas, The eligibility criteria in Maryland’s medical parole statute are different from those listed in the Code of Maryland Regulations, which are intended to implement it;[2] and

Whereas, Michigan does not have any guidelines for the implementation of its compassionate release policy whatsoever;[2] and

Whereas, Between 2011 and 2016, 30 incarcerated individuals died while navigating the compassionate release process in Georgia, where there are no guidelines for the processing and referral of eligible patients to the Georgia Board of Pardons and Paroles;[2] and

Whereas, In some states including Kansas, eligibility for compassionate release requires a prognosis of only 30 to 60 days to live, even though the review process for compassionate release can take many months;[2] and

Whereas, Only 13 states have a statutory or regulatory reporting requirement for their compassionate release programs, and of those states, very few make that information public,[2] making it often impossible to analyze outcomes; and

Whereas, Each year over 2,600 incarcerated people appeal to the Federal Bureau of Prisons (BOP) for compassionate release, but 97% of requests are denied; reasons for denial include: failure to meet strict eligibility requirements, public concern for recidivism, and inadequate post-release planning;[9,10] and

Whereas, A 2013 study by the U.S. Department of Justice Office of the Inspector General found that of 142 incarcerated individuals approved through the BOP's compassionate release program between 2006 and 2011, only five had been re-arrested within a three-year timeframe, representing a recidivism rate of just 3.5%[7], compared to an average rate of recidivism of 68% within three years for all prisoners;[11] and

Whereas, In 2016, the United States Sentencing Commission adopted a new set of eligibility guidelines for use in federal compassionate release cases based on recommendations from medical and policy experts; however, these guidelines are not legally binding for the BOP and many states do not conform to these guidelines;[12] and

Whereas, Eligibility guidelines for state compassionate release programs rarely account for current medical evidence related to serious illness, health trajectories in the seriously ill and aging, and prognosis, leading to, for example, routine exclusion of individuals with dementia, which causes serious disability well before death;[12] and

Whereas, Between 2013 and 2017, the BOP received about 5,400 applications for compassionate release, and as of March 2018, 312 of those applicants have been approved, while 266 have died waiting;[13] and

Whereas, The Granting Release and Compassion Effectively (GRACE) Act of 2018 is a legislative proposal currently under consideration in the United States Senate that would promote efficient preparation and processing of sentence reduction requests for compassionate release, in addition to mandatory reporting on compassionate release from the BOP;[14] therefore be it

RESOLVED, That our AMA advocate for policies that promote compassionate release on the basis of serious medical conditions and advanced age; and be it further

RESOLVED, That our AMA support federal and state reforms that ensure efficient preparation and processing of sentence reduction requests for compassionate release; and be it further

RESOLVED, That our AMA collaborate with the National Commission on Correctional Healthcare and state medical societies to draft model legislation that establishes clear, evidence-based eligibility criteria for an efficient compassionate release process; and be it further

RESOLVED, That our AMA promote mandatory annual reporting by compassionate release programs to the Bureau of Justice Statistics, including numbers of applicants, approvals, denials, and revocations, as well as reasons for decisions and demographic information.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

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.

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.

Dignity and Self Respect H-25.997
The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 5
(I-18)

Introduced by: Region 4; Student National Medical Association (SNMA)

Subject: Inclusion of Pregnant Women in the Secondhand Smoke Driving Ban

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, There is strong evidence that secondhand smoke (SHS) is risky for a developing fetus, correlating with congenital health conditions, stillbirths, and developmental delays;[1,2] and

Whereas, Babies whose mothers were exposed to SHS while pregnant were more likely to be born prematurely (25.6%) compared to babies whose mothers were not exposed to SHS while pregnant (10.5%);[2] and

Whereas, Prenatal SHS exposure results in lower birth weights;[3,4] and

Whereas, Research indicates a decrease in gross motor function, fine motor function, and communication in toddlers whose mothers were exposed to SHS while pregnant, suggesting neurodevelopmental delay;[5,6] and

Whereas, Prenatal exposure to SHS was also associated with an increased risk of hyperactive behavior in children;[7] and

Whereas, SHS is harmful to pregnant women, who reported having a poorer quality of life in comparison to non-exposed pregnant women;[8] and

Whereas, Smoking in vehicles resulted in increased levels of several biomarkers for SHS in non-smoking passengers;[9,10] and

Whereas, Studies indicate that the “concentration of toxins in a smoke-filled car is 23 times greater than that of a smoky bar”;[11] and

Whereas, Results of a smoking ban in public places show significant reductions in pregnant women’s levels of cotinine (a biomarker of nicotine metabolism, indicating SHS exposure);[12] and

Whereas, The AMA (H-490.913, Smoke-Free Environments and Workplaces) currently supports smoke-free public places, protecting many populations from SHS including children, patients, and the general workforce, but there is no support for protecting pregnant women from SHS in vehicles; therefore be it

RESOLVED, That our AMA amend policy H-490.910, Secondhand Smoke, by addition as follows:

Secondhand Smoke, H-490.910

1. Our AMA urges the President of the United States to issue an Executive Order making all federal workplaces, including buildings and campuses, entirely smoke free and urges its federation members to do the same.
2. Our AMA supports legislation that prohibits smoking while operating or riding in a vehicle that contains children and pregnant women.

Fiscal note: Minimal, 6

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Secondhand Smoke H-490.910
1. Our AMA urges the President of the United States to issue an Executive Order making all federal workplaces, including buildings and campuses, entirely smoke free and urges its federation members to do the same.

2. Our AMA supports legislation that prohibits smoking while operating or riding in a vehicle that contains children.

Smoke-Free Environments and Workplaces H-490.913
On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA:

(1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government;

(2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws.

(3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants,

particularly fast food restaurants, and convenience stores to immediately create a smoke-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia;

(4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts;

(5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools;

(6) will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and

(7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues.

Banning Smoking in All Workplaces D-490.970
Our AMA will (1) actively support national, state, and local legislation and actively pursue regulations banning smoking in all workplaces; and (2) work to ensure that federal legislation banning smoking in all workplaces does not prohibit or weaken more strict state or local regulations.

Banning Smoking While Driving in Vehicles in which Minors are Present 490.024MSS
AMA-MSS will ask the AMA to support legislation that prohibits smoking while operating or riding in a vehicle that contains children. (MSS Res 25, A-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 6
(I-18)

Introduced by: Region 5

Subject: Promoting Research into the Effects of Net Neutrality on Public Health

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, “Net neutrality” is the principle that, “all traffic on the Internet should be treated the same,” by preventing interference of the flow of content, services, and applications by internet service providers (ISPs)[1], and

Whereas, Internet service providers (ISPs) are business entities who provide internet services and host websites[2], and

Whereas, Federal Communications Commission (FCC) Order 15-24 (2015) classified ISPs as Title II information providers per the Telecommunications Act of 1996, thereby subsuming ISPs to “common carrier” categorization[3], and

Whereas, A “common carrier” is a private entity that facilitates the free flow of commerce by transportation, communications, and other services, with the legal obligation of doing so in a non-discriminatory and censorship free manner[4], and

Whereas, Recent repeal of comprehensive net neutrality rules now removes Title II regulations on ISPs, and by extension, their “common carrier” classification[5], and

Whereas, ISPs are now able to block content from websites or apps, throttle--slow---bandwidth, and prioritize hosting sites, i.e. “fast lane” programs, for entities willing to pay premiums4, and

Whereas, Throttling and regulating quality of service (QoS) would alter end user choice of service, thereby increasing discrimination and segmentation of internet access for consumers6, and

Whereas, “eHealth” loosely describes a compendium of disparate themes, e.g. myriad health, commerce, and technology, e.g. internet services[6], and

Whereas, Individuals with greater internet access are more likely to use eHealth[7], and

Whereas,” eHealth” users are more likely to visit a doctor, use preventative health measures, have shorter hospital stays, and have overall better health outcome and[7], and

Whereas, Net neutrality, in facilitating “eHealth”, potentially improves patient services, reduces healthcare costs, and improves population health[8], and

Whereas, Individual pricing of internet access could lead to the favorability of certain services and contents, including but not limited to, health insurance options, telehealth services, and electronic health record services[2], and

Whereas, Telehealth has been shown to improve healthcare for those with limited access to healthcare through services such as remote rehabilitation and maternal and child health[9,10,] and

Whereas, The utilization of telehealth can expand the patient pool available for recruitment to clinical studies furthering medical research[11], and

Whereas, ISPs such as Verizon and Comcast are heavily invested in healthcare companies such as Oncare and Onpatient respectively[1], and

Whereas, Verizon has used non-neutral practices to give Oncare a competitive advantage over competitors such as MedicalAlert through preferred network access[1], and

Whereas, Net neutrality repeal may decrease consumer access to healthcare and insurance providers, and further contribute to the increasing prices of pharmaceutical products via the prioritization of certain drug providers[12], and

Whereas, Net neutrality repeal may lead to deficits in medical training, insofar as net neutrality promotes open access resources to which physicians-in-training turn[13], and

Whereas, Existing AMA policy advocates for the promotion and evaluation of barriers of internet based health records (D-478.979), which changes to net neutrality could have an effect on, and

Whereas, Existing AMA policy advocates for the promotion of policies that combat escalating prescription drug cost (H-110.988), which alterations to net neutrality and market competition could have an effect; therefore be it

RESOLVED, That our AMA research the effects that the repeal of net neutrality rules will have on healthcare accessibility, health insurance, online health resources, electronic health records, telemedicine, and pharmaceutical company advertising.

Fiscal note: Moderate, 10

Date Received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Promoting Internet-Based Electronic Health Records and Personal Health Records D-478.979
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.
(BOT Rep. 11, I-1)

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.
(Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Reaffirmed in lieu of: Res. 207, A-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 7
(I-18)

Introduced by:	Region 1; Alexandra Clement, University of Connecticut
Subject:	Opposing Unregulated, Non-Commercial Firearm Manufacturing
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, The United States has the highest rate of gun ownership in the world with 120.5 guns per 100 residents, indicating that the U.S. has more guns than people;[1] and

Whereas, Evidence across ecological, cross-sectional, and case-control studies suggests that gun availability is a significant risk factor for homicide and suicide;[2,3] and

Whereas, A 2015 study found that a 1% increase in firearm ownership rates is associated with an average increase of 0.16 deaths by suicide per 100,000 individuals;[3] and

Whereas, The case fatality rate of firearm suicide is 85%, making firearms the most lethal means of suicide attempt;[4] and

Whereas, In 2015, 73% of homicide victims were murdered with a firearm (12,979 deaths) and 50% of suicides were completed with a firearm (22,018 deaths);[5] and

Whereas, 3-D printers cost less than $1,000, thus, there is a concern that the accessibility of this technology could lead to the proliferation of amateur gun making in homes across the U.S.;[6] and

Whereas, 3-D printed guns pose a threat because they are easy to fabricate, may not look like real guns, and may be especially appealing to children and adolescents;[6,7] and

Whereas, On August 1, 2018, the U.S. State Department prepared to allow the “Defense Distributed” firm to publish gun blueprints for 3-D printers, although this was overturned by a federal judge;[8,9] and

Whereas, Hundreds of blueprint designs were reportedly downloaded prior to this court decision;[8] and

Whereas, With access to a 3-D printer, downloading a firearm blueprint enables the manufacturing of a plastic, untraceable firearm without a criminal background check or a serial number requirement, such as an AR-15 semi-automatic assault weapon;[8,9] and

Whereas, Metal parts may be added to make 3-D printed firearms legal under the Undetectable Firearms Act of 1988, although these firearms are still manufactured without a criminal background check or a serial number;[9] and

Whereas, There is precedent for municipality law, such as that of New South Wales in Australia, to regulate blueprints that may be used to 3-D print firearms;[10] and

Whereas, The U.S. has taken previous action prohibiting the demonstration of manufacturing or usage of explosives, destructive devices, or weapons of mass destruction as well as any means of distribution of information pertaining to the manufacturing or use of the aforementioned devices;[11] and

Whereas, Using blueprints to 3-D print firearms will increase access to guns in an unregulated manner, and the literature suggests that increased access results in an increase in the number of homicides and suicides;[2,3,4] therefore be it

RESOLVED, That the AMA support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and be it further

RESOLVED, That the AMA issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue; and be it further

RESOLVED, That this matter be immediately forwarded to the AMA House of Delegates at Interim 2018.

Fiscal note: Significant, 12

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

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

Firearm Availability H-145.996
1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA policy is to require the licensing of owners of firearms including completion of a required safety course and registration of all firearms.
3. Our AMA supports local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding “concealed carry”, by supporting “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and by supporting “red-flag” laws for individuals who have demonstrated significant

signs of potential violence. In supporting local law enforcement, we support as well the importance of “due process” so that decisions could be reversible by individuals petitioning in court for their rights to be restored.

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

Control of Non-Detectable Firearms H-145.994
The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices.

Handgun Violence 145.001MSS
The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12)

Regulation of Handgun Safety and Quality 145.009MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 8
(I-18)

Introduced by:	Region 1; Region 4; Region 5; Ajeet Singh, Loyola University Chicago Stritch School of Medicine
Subject:	Support for Housing Modification Policies
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, The US population of older adults aged 65+ was 49 million in 2017,[1] 17% of the population, and is projected to increase to 80 million by 2040, 22% of the population;[2] and

Whereas, One in four Americans aged 65+ fall each year, leading to medical treatment in the emergency room every 11 seconds, and a death every 19 minutes;[3] and

Whereas, Falls are the leading cause of fatal and non-fatal injuries among older adults, and also represent the primary cause of traumatic brain injury and hip fracture;[4] and

Whereas, The average hospital cost of treating a fall is over $30,000 with higher costs associated with increasing age;[5] and

Whereas, In 2015, the total medical costs in the United States for falls was more than $50 billion with Medicare and Medicaid shouldering 75% of the costs;[6] and

Whereas, As the aging population increases, the costs for older adult falls is expected to reach $67.7 billion by 2020;[3] and

Whereas, Long-term effects of fall injuries are not accounted for in direct medical costs which include disability, dependence on others, lost time from work and household activities, and reduced quality of life;[7] and

Whereas, Approximately 35% of individuals aged 65 years+ characterized themselves as having ambulatory disabilities such as difficulty walking or climbing stairs, leading to an increased fall risk;[1] and

Whereas, Over 40 million Americans live with a disability as defined by having serious difficulty with hearing, vision, cognition, walking or climbing stairs, or difficulty with self-care and independent living, leading to an elevated risk of falling;[1] and

Whereas, 89% of Americans aged 50+ would like to remain living in their homes for as long as possible;[8] however, 1 in 3 adults aged 65+ have trouble using kitchen, bedroom, bathroom, and access features of their homes;[9] and

Whereas, The community-based long term care program, Aging in Place, which supports seniors to live in their residence of choice as they age, costed Medicare and Medicaid approximately $20,000 less per person per year than nursing home care;[10] and

Whereas, House hazards are the greatest contributing factor to fall risk, even when compared to medical comorbidities that contribute to poor balance and vision impairment;[11] and

Whereas, The American Geriatric Society examined the cost-effectiveness of fall prevention programs, and found that home modifications provide the best value at $14,794/quality-adjusted life year (QALY) with the QALY valued at $50,000 or $100,000;[12] and

Whereas, When compared to six other evidence-based fall interventions, housing modifications had potential to help the greatest number of the elderly, at 38.2 million older adults, an estimated $442 million in direct medical costs to Medicare averted, and 45,164 medically treated falls prevented annually;[11] and

Whereas, A cost-benefit analysis using disability adjusted life years showed a reduction in medical costs by 33% for the elderly living in homes with modifications, and that the savings from injuries prevented were at least six times the costs of the intervention with the benefit-cost ratio more than doubling for older people and increasing by 60% for those with a history of fall injuries;[13] and

Whereas, Medicare Part A and B covers over 59 million people, comprising of approximately 50 million aged and 9 million disabled individuals;[14] and

Whereas, Medicare and most private insurers do not provide coverage for housing modifications[15,16] and 80% of housing modifications are paid for by the primary occupants of the residence;[17] and

Whereas, In April 2018, Medicare Part C, also known as Medicare Advantage, approved the broad coverage of home safety devices and modifications for contracting insurance companies in order to reduce hospitalizations and improve patient health;[18] and

Whereas, Although Medicaid provides some form of financial assistance for home modification across most states[19], Medicaid health coverage extends to only 6 million seniors[14] and 20% of total Medicare beneficiaries;[20] and

Whereas, Only 12 states have instituted legislation providing state-level tax credits to assist people modifying their homes for the purpose of increasing safety and accessibility;[21] and

Whereas, H.R.1780 (2017-2018) was introduced to provide seniors with a federal tax credit for the purpose of modifying their homes to be able to live safely and independently;[22] therefore be it

RESOLVED, That our AMA support legislation and other efforts to promote housing modifications as a means of falls prevention and improved disability access, which may include but are not limited to

a) health insurance coverage of housing modification benefits
b) tax credits and other financial incentives to increase the affordability of home modifications
c) other federally or state funded programs that provide home modification benefits.

Fiscal note: Significant, 12

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Geriatric Medicine H-295.981:

1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.

2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.

Health Care for Older Patients H-25.999:

The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum..

Clinical Preventive Services H-425.984:

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based

preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

Community-Based Falls Prevention Programs H-25.988
Our American Medical Association will work with relevant organizations to support community-based falls prevention programs.

Healthy Lifestyles H-425.972
1. Our AMA: (A) 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; (B) 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 (C) 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.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Reward-Based Incentive Programs for Healthy Lifestyles H-170.963
Our AMA:

(1) Supports an integrated approach to encouraging the adoption of healthy lifestyles, involving coordinated efforts by physicians, other health care providers, insurers, employers, unions, and government.
(2) Policy is that reward-based incentive programs that are developed to promote healthy lifestyles should be guided by the following principles:
(a) Incentive programs should be designed with input from physicians.
(b) Incentive programs should reward behaviors, not health status.
(c) Programs should be designed to assess and address risk factors as well as current health status.
(d) Program participation should allow for at least some level of individual assessment and feedback.
(e) Confidentiality of program participants must be maintained, possibly through use of a third-party vendor to track individual participation.
(f) Incentives should be integrated into an ongoing risk-reduction and behavior change program to encourage and support long-term changes in habits and behaviors.

(g) To the extent possible, efforts should be made to ensure that other policies, resources, and activities support and facilitate participation in healthy behaviors.

(3) Our AMA advocates that Medicare, Medicaid, Disability and other publicly-funded health insurance programs incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.

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.

Preventive Medical Care Coverage for All H-165.840
Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 9
(I-18)

Introduced by: Region 3; Avneet Soin, Tufts University School of Medicine

Subject: Support Standardization of Care for Postpartum Hemorrhage

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, the United States has the highest maternal mortality rate of any developed country, with nearly 700 women dying annually from pregnancy-related complications, one of which being postpartum hemorrhage;[1, 2] and

Whereas, the American College of Obstetricians and Gynecologists (ACOG) defines postpartum hemorrhage as a "cumulative blood loss of greater than or equal to 1,000 mL or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process;" [3] and

Whereas, ACOG recognizes obstetric hemorrhage as a leading cause of maternal death and recommends standard, hospital-wide protocols to help coordinate response and management of care; [1, 3] and

Whereas, the ACOG partners with organizations such as the Alliance for Innovation on Maternal Health (AIM) to focus on the implementation of standard and consistent care for many conditions, including postpartum hemorrhage; [5] and

Whereas, a report published in 2017 by the Nine Maternal Mortality Review Committees (MMRC) concluded that the most common contributing factor to hemorrhage-related pregnancy death was improper risk assessment due to inconsistent protocols for diagnosis, management, consultation and referral; [6] and

Whereas, Nine MMRC, the World Health Organization and the Safe Mother Initiative have used the national and international expertise of obstetricians and gynecologists to analyze current practices and create recommendations for improved training, communication and coordination between providers as well as evidence-based standards of care to decrease morbidity and mortality from pregnancy-related hemorrhage; [6, 7, 8, 9] and

Whereas, the California Maternal Quality Care Collaborative (CMQCC), a multi-stakeholder organization established in 2006, has used research, standardized quality improvement toolkits and statewide initiatives to address the preventable causes of maternal morbidity and mortality, which has shown a 55% reduction in overall maternal mortality; [4, 9, 10] and

Whereas, states such as Georgia and Florida that have higher incidences of postpartum-related maternal mortality and morbidity have already begun implementing standardized

protocols utilizing the resources from ACOG and the CMQCC with measured success;[11,12] therefore be it

RESOLVED, that our AMA-MSS support the standardization of care, and establishment of formal protocols for the management of postpartum hemorrhage.

Fiscal Note: Minimal, 4

Date Received: 09/23/2018

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12. A Quality Improvement Initiative For Obstetric Hemorrhage Management. *Florida Perinatal Quality Collaborative.* 2015.

RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal

mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

State Maternal Mortality Review Committees H-60.909

Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Support for Hemorrhage Control Training H-130.935

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 10
(I-18)

Introduced by:	Andrew Wodrich, Patrick Keller, Lincoln Shade, TJ Libecap, Marcus Rommelman, and Rachel Whittaker, University of Kentucky College of Medicine
Subject:	Support for the Delegation of Informed Consent Procurement
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Per the AMA Code of Medical Ethics, informed consent is deemed to have been given when, "communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention";[1] and

Whereas, Per the AMA Code of Medical Ethics, the role of the physician in obtaining informed consent is, "to present the medical facts accurately to the patient … to make recommendations for management in accordance with good medical practice … to help the patient make choices from among the therapeutic alternatives consistent with good medical practice . . . [and to] sensitively and respectfully disclose all relevant medical information to patients";[2] and

Whereas, The facts of the case of *Shinal v. Toms*, a recent court case focused on informed consent heard in the Supreme Court of Pennsylvania, are that Ms. Shinal sued Dr. Toms, a neurosurgeon, for damages after he performed surgery on Ms. Shinal that resulted in permanent neurological impairment; Dr. Toms had answered Ms. Shinal's questions, reviewed risks of the procedure, and explained alternative treatment options; and Dr. Toms had his physician-assistant answer further questions and obtain Ms. Shinal's consent for the surgery;[3,4] and

Whereas, The Supreme Court of Pennsylvania ruled in *Shinal v. Toms* that the obtaining of informed consent is a non-delegable duty; that is, the court stated that the jury could not consider information provided to the patient by the surgeon's staff when deciding the merits of the claim;[3] and,

Whereas, Prior to the *Shinal v. Toms* ruling, it was not uncommon for medical care team staff to aid the treating physician in the process of obtaining informed consent;[5] and

Whereas, Following the ruling in *Shinal v. Toms*, "Pennsylvania physicians are legally required to perform [the informed consent procurement] on their own";[4] and

Whereas, New York, Oregon, Texas, and Wisconsin all currently have medical care laws with non-specific wording regarding the procurement of informed consent that could lead to similar rulings to that of *Shinal v. Toms* in these and other states across the country;[4] and

Whereas, Physicians work on average 2524 hours annually, with those in surgical subspecialties working on average an additional 303 hours annually, corresponding to 48.5 and 54.4 hours worked per week, respectively;[6] and

Whereas, The AMA and the Pennsylvania Medical Society filed an amicus brief prior to the ruling in *Shinal v. Toms* arguing in favor of Dr. Toms that, "[t]here is nothing unusual about the physician having a duty, and the ultimate liability, but also having the authority to delegate performance of the duty. The 'captain of the ship' doctrine reflects precisely that point";[7] and

Whereas, While concerns have been raised that junior medical staff such as residents may have not yet have had specialized training in informed consent, undertaking this role under the supervision of the treating physician is an important part of their learning about the informed consent process;[8,9] and

Whereas, Concern may be raised that staff other than the attending physician lack the medical knowledge to provide patients with information during the informed consent process, experienced resident physicians, nurse practitioners, and physician assistants, such as the physician assistant in *Shinal v. Toms* who had assisted in the informed consent process approximately 40 times prior to Ms. Shinal's operation, should not be prevented from performing supplemental tasks such answering patient follow-up questions or providing additional information under supervision by the attending physician;[7] and

Whereas, A study focused on patient learning showed that during informed consent discussions, the total time a medical professional spent with a patient was the strongest predictor of patient comprehension, and therefore inclusion of supervised care team members in the informed consent procurement process could increase this vital time spent on patient understanding;[10] and

Whereas, Patients can benefit from supplementary communication and exploration of their preferences provided by qualified staff prior to undergoing surgery;[11] and

Whereas, The AMA currently supports the movement towards physician-led, patient-centered, team-based medical care;[12,13] and

Whereas, The *Shinal v. Toms* decision is, "contrary to a holistic, team-based approach to medical care, where information disclosure facilitates a shared decision-making model";[14] therefore be it

RESOLVED, That our AMA support the ability of treating physicians to delegate aspects of procuring informed consent from a patient to a qualified and supervised patient care

team member consistent with accepted standards of medical practice, while retaining the ultimate responsibility for the acceptable procurement of this consent.

Fiscal Note: Moderate, 10

Date Received: 09/23/18

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2. Opinion 8.08 – Informed Consent. *American Medical Association Code of Medical Ethics*. *Virtual Mentor*. 2013; 15(1):1301.
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12. AMA Policy D-35.982.
13. AMA Policy D-35.985.
14. Teo W. *et al*. Medicolegal Sidebar: Who Should Obtain Informed Consent? *Clin Orthop Relat Res*. 2018;476(8):1566-1568.

RELEVANT AMA AND AMA-MSS POLICY:

Informed Consent 2.1.1

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient

lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982
1. Our AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.

2. Our AMA will assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety.

3. Our AMA will actively oppose health care teams that are not physician-led.

Support for Physician Led, Team Based Care D-35.985
Our AMA:
1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients' access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

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.

Bioethical Determinations 140.002MSS

Bioethical Determinations: It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions regarding his or her own health care and the determination of who makes decisions for health care in the non-competent patient.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 11
(I-18)

Introduced by: Region 2; Region 5

Subject: Improving Body Donation Regulation

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Body donation has been and will continue to be essential to medical-surgical education, clinical practice, and research, even as new virtual technology emerges;[1,2,3,4,5,6,7,8,9,10,11,12,13] and

Whereas, Donated bodies are utilized for many continuing education programs, which are a requirement of the medical profession;[3,10,14,15,16,17] and

Whereas, Research and education conducted on donated bodies is beneficial to patients, society, and the medical profession;[14,17,18,19,20,21] and

Whereas, Body donation, transplant tissue donation, and vascular organ donation are all examples of how an individual person may donate part or all of his or her body to the institutions of science and medicine;[22,23,24] and

Whereas, Transplant tissue and vascular organ donations are heavily regulated on a federal level by the Food and Drug Administration and the Health Resources Service Administration, respectively;[25,26,27] and

Whereas, Transplant tissue and vascular organ donations stay within the medical infrastructure via a chain of custody that is monitored on a national level, as set forth by the Food and Drug Administration and the National Organ Transplant Act of 1984, respectively;[25,26,28] and

Whereas, Existing AMA Policy (H-370.988) demonstrates that the AMA has supported federal oversight for processes involving human donation to the medical profession; and

Whereas, Body donation is classified as neither transplant tissue donation nor vascular organ donation and is thus not regulated by either Food and Drug or the Administration the Health Resources Service Administration, creating a gap in federal oversight and resulting in state and institutional level regulation;[16,29,30] and

Whereas, Body donation practices lack transparency and consistency across institutional and state practices, creating loopholes between federal, state, and institutional policy;[16,29,30,31,32] and

Whereas, The lack of consistent and appropriate monitoring of bodies and body parts can result in lost tissues and incorrectly returned remains; [30,33] and

Whereas, The lack of regulation allows market incentives to promote unethical body part acquisitions and thus impels institutions, research teams, and individual health care providers to set their own ethical bar;[30,31,32] and

Whereas, The current unregulated structure of body donation allows misleading marketing that focuses on financial incentives (e.g., free cremation) and does not clearly explain how donated bodies are used, which leads to an incongruence between donor/family wishes and understanding, and the resulting use of their bodies;[29,32,34] and,

Whereas, The current unregulated structure of body donation disproportionately affects poor and minority communities due to advertising and financial incentives;[29,34,35] and

Whereas, Existing AMA Policy - Code of Ethics (6.1.3) and AMA-MSS Policy (370.015MSS) clearly outline the importance of removing potential financial incentives for organ donation, but there are no analogous policies for body donation; and

Whereas, There are examples of institutional and professional organizational guidelines (i.e. by medical schools, The International Federation of Associations of Anatomists) for ethical and productive body donation programs that could inform federal regulation;[36] and

Whereas, The requirements of donated bodies for research and education purposes does not outweigh the ethical obligations of the profession;[37] therefore be it

RESOLVED, That our AMA establishes a task force to investigate body donation practices, regulations, and loopholes in the United States; and be it further

RESOLVED, That our AMA lobbies and advocates for ethical, transparent, and consistent body donation regulations that align with the wishes of donors and their families.

Fiscal Note: Significant, 12

Date Received: 9/23/18

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RELEVANT AMA POLICY:

6.1.3 Studying Financial Incentives for Cadaveric Organ Donation

Physicians' ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence.

Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

(a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.

(b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.

(c) Has been developed in consultation with the population among whom it is to be carried out.

(d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.

(e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

Regulation of Tissue Banking H-370.988

Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues.

State Regulation and Licensing of Human Tissue Banks H-370.989

Our AMA encourages states to require licensing of human tissue banks in a manner consistent with the Food and Drug Administration's federal regulatory requirements.

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA: (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members; and (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Organ Donation D-370.985

Our AMA will study potential models for increasing the United States organ donor pool.

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.

RELEVANT AMA-MSS POLICY

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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 12
(I-18)

Introduced by: Sneha Swaminathan, Akhil Chandra, Chaewon Hwang, Mallika Tatikola, Rutgers Robert Wood Johnson Medical School

Subject: Modernizing Patient Gown-ing Practices in Healthcare

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Loss of patient comfort and loss of patient dignity are at risk in a hospital environment due to the lack of privacy, focus on healthcare provider needs over patient needs, and necessity of physical examinations;[1,2] and

Whereas, Patient comfort and dignity are important components of patient care, yet, healthcare professionals are largely unaware of the negative effects of increased bodily exposure due to current patient gown-ing etiquette;[3,4] and

Whereas, Patient gowns are unique in their utility towards two end-users: the wearer and the caregiver. However, current gown-ing practices cater solely towards the caregiver through their reverse-closing, string-tied, and torso-concealing design, which makes it difficult for patients to independently wear their gowns and to remain comfortably unexposed;[2,5] and

Whereas, A study published within The Journal of the American Medical Association regarding modification of gown-ing practices discovered that 76% of patients preferred additional concealment while wearing traditional patient gowns;[6] and

Whereas, The Henry Ford Health System demonstrated that improving patient gown coverage by utilizing an updated gown that wraps around the body like a bathrobe markedly increased patient satisfaction scores;[7,8] and

Whereas, While patient gown designs with increased concealment are available, the majority of hospitals and healthcare systems have not adopted these options;[8,9,10] and

Whereas, Although the AMA Code of Medical Ethics aims to advocate for patient dignity through multiple efforts including providing “appropriate gowns,” standards have not been established to define “appropriate gowns” or to evaluate patient satisfaction of current gown-ing practices (AMA 1.2.4);[11] therefore be it

RESOLVED, That our AMA encourage hospital systems and appropriate regulatory bodies to establish standards for gown design that improve patient comfort while preserving gown function.

Fiscal note: Moderate, 6

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Use of Chaperones AMA 1.2.4
Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.
Physicians should:

(a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients
(b) Always honor a patient's request to have a chaperone.
(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
(d) In general, use a chaperone even when a patient's trusted companion is present.
(e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 13
(I-18)

Introduced by:	Region 2; Neil K. Jain, Sulman Mahmood, Rowan University School of Osteopathic Medicine; Kunj Jain, Yash Shah, New Jersey Medical School
Subject:	Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, The opioid crisis is a well-known public health epidemic in the United States and more than 115 people die every day from opioid overdose in the US according to the National Institute of Health;[1,2,3] and

Whereas, Existing AMA policy "encourages the education of healthcare workers and opioid users about the use of naloxone in preventing opioid fatalities" (D-95.987); and

Whereas, Many medical schools have addressed this public health crisis by supplementing Basic Life Support (BLS) training with naloxone training and opioid education;[3,4,5,6] and

Whereas, For example, naloxone training was held in conjunction with the Basic Life Support (BLS) training at the New York Medical College where students are required to become certified in naloxone adminsitration;[4] and

Whereas, At Harvard Medical School, a group of medical students, emergency medicine educators, and administrators have worked together to permanently integrate naloxone rescue training into the Basic Life Support (BLS) curriculum required of all first-year medical students;[6] and

Whereas, Medical students in school with Opioid Overdose Prevention Training as an adjunct to Basic Life Support (BLS) training have self-reported increased preparedness to respond to opioid overdoses;[7] and

Whereas, Existing AMA Policy, reaffirms their commitment to "improving access to treatment for substance use disorders" (D-160.981); and

Whereas, Increased access and use of naloxone improve patient mortality and patient outcomes by 14% and specifically 23% amongst the African American population; [8,9] and

Whereas, Access to naloxone is not easily accessible causing a barrier to implementing effective opioid overdose treatment; [10,11] therefore be it

RESOLVED, That Our AMA collaborate with the American Heart Association and American Red Cross to incorporate naloxone training into the Basic Life Support (BLS) Certification Program; and be it further

RESOLVED, That Our AMA collaborate with the Occupational Safety and Health Administration to include naloxone rescue kits in first aid equipment.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Prevention of Opioid Overdose D-95.987– Our AMA: (1) 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) 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; (3) will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985– Our AMA (1) will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice; (2) in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management; (3) will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.

Promotion of Better Pain Care D-160.981– Our AMA: (1) 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; and (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; (2) encourages relevant stakeholders to research the overall effects of opioid production cuts; (3) strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages; (4) encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines; (5) 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.

Integrating Content Related to Public Health and Preventive Medicine across the Medical Education Continuum D-295.327– Our AMA (1) 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) 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) actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education;(4) through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content; (5) supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents; (6) 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

Increasing Availability of Naloxone H-95.932– Our AMA (1) 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) supports efforts that enable law enforcement agencies to carry and administer naloxone; (3) 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) 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) 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) supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively; (7) encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration; (8) urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 14
(I-18)

Introduced by: Region 2, Region 5; Student National Medical Association (SNMA)

Subject: Increasing PrEP Access by Advocating for Generic Entry into the U.S. Marketplace

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, According to the Centers for Disease Control (CDC), there are over one million people living with HIV/AIDS in the United States;[1] and

Whereas, in 2015, there were 38,500 new HIV infections in the United States and 6,465 people died from AIDS-related complications;[2] and

Whereas, Fixed dose combinations of tenofovir disoproxil fumarate and emtricitabine (TDF/FTC) are indicated for use as pre-exposure prophylaxis (PrEP) taken regularly by high-risk individuals without HIV to reduce their risk of acquiring the virus through sexual or bloodborne contact;[3] and

Whereas, Daily use of TDF/FTC PrEP was associated with a 99% reduction in risk of HIV acquisition among MSM and transgender women;[4] and

Whereas, Over 1.2 million Americans have an indication to be on PrEP based on the US Public Health Service PrEP guidelines, but as of 2017, no more than 117,000 people are on it;[5,6] and

Whereas, One model looking at reduction of HIV incidence in New York City estimated that, given 75% efficacy and 90% uptake of PrEP in MSM, new cases of HIV could be reduced by 47%;[7] and

Whereas, In New South Wales, Australia, a program providing free access to PrEP led to a drop in HIV diagnoses among MSM by 35% in just six months, one of the fastest declines recorded since the global AIDS crisis began;[8] and

Whereas, The global cost of manufacturing generic PrEP is estimated to be ~$6 for a 30-day supply, but the average cost charged for a 30-day supply, as of May 2018, is $1,600;[9,10] and

Whereas, Although the chemical formulation of TDF/FTC is protected by two patents until 2021, the intellectual property on these patents are products of federally funded research;[11,12] and

Whereas, products of federally-funded research are subject to March-In Rights and other governmental rights pursuant to the Bayh-Dole Act (Patent and Trademark Law Amendments Act);[13] and

Whereas, March-In Rights are a provision of the Bayh-Dole Act that allows a federal agency to ignore the exclusivity of a patent on federally-funded research and grant additional licenses to other "reasonable applicants," such as generic manufacturers;[14] and

Whereas, Grassroots activists from the PrEP4All Collaboration and the #BreakThePatent campaign have developed recommendations that the federal government utilize the aforementioned legislative rights to form contracts with generic manufacturers and distribute the medication, all a cost less than what our healthcare system currently spends to get PrEP to less than 10% of the high-risk population;[15,16] and

Whereas, Existing AMA policy H-20.895 and AMA-MSS policy 20.020MSS do not adequately address the fundamental issue of PrEP cost; therefore be it

RESOLVED, That our AMA-MSS will ask that our AMA advocate for federal use of existing legislation to grant immediate entry of generic tenofovir disoproxil fumarate and emtricitabine (TDF/FTC) in the US marketplace.

Fiscal Note: Significant, 12

Date Received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Increase Access to HIV PrEP for At-Risk Individuals 20.020MSS
AMA-MSS supports PrEP referral at needle exchange sites. (MSS Res 26, A-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 15
(I-18)

Introduced by: Region 1

Subject: Opposing Office of Refugee Resettlement's Use of Medical/ Psychiatric Records for Evidence in Immigration Court

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, It is now policy that unaccompanied immigrant children and those accompanied by their parents all must be placed under the custody of Office Refugee Resettlement (ORR) of the Department of Health and Human Services (HHS);[1] and

Whereas, In 2017, 40,810 unaccompanied immigrant children were referred to ORR, where the average length of stay was 41 days;[2] and

Whereas, Children in ORR custody frequently receive medical and mental health services during their detainment;[3] and

Whereas, Confidential medical and psychological records and social work case files from ORR are increasingly showing up in immigration court as evidence for deportation or further detainment;[4,5] and

Whereas, Before a child reaches the age of 18 they cannot exercise their own HIPAA rights without the signature of a parent or guardian;[6] and

Whereas, Children in detainment don't have access to their own HIPAA rights because they are separated from their parents who also might be detained or are in fear of deportation by claiming sponsorship, and the HIPAA Privacy Rule only allows covered entities (including healthcare providers) to disclose protected health information to law enforcement officials under specific limited circumstances (e.g. to comply with a court order or court-ordered warrant, a subpoena or summons);[5,7] and

Whereas, Breaches in patient confidentiality, or the perceived threat thereof, create distrust in the healthcare system and lead to patients delaying or forgoing medical care, particularly in immigrant populations;[8,9,10] and

Whereas, Children separated from parents during development has been linked with later risk of criminality and mental health issues such as bipolar disorder and schizophrenia;[11,12] and

Whereas, Undocumented children forcibly separated from parents at the US border in order to be detained has been shown to increase risk of post-traumatic stress disorder, anxiety, depression, aggression and suicidal ideation;[13,14] and

Whereas, Existing AMA policy calls for our AMA to “work with medical societies and all clinicians to work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being” (D-60.968); and

Whereas, Existing AMA policy directs our AMA to “recommend the U.S. Immigrations 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” (D-350.983); and

Whereas, Existing AMA policy instructs 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); therefore be it

RESOLVED, That our AMA advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children; and be it further

RESOLVED, That our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts to facilitate further detainment or deportation, particularly for minors; and be it further

RESOLVED, That this matter be immediately forwarded to the AMA House of Delegates at Interim 2018.

Fiscal note: Significant, 10

Date received: 09/23/18

References:

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RELEVANT AMA AND AMA-MSS POLICY:

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

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations 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; and (3) advocate for access to health care for individuals in immigration detention.

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.

Improving Medical Care in Immigration Detention Centers 350.016MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations 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; and (2) recommend the U.S. Immigrations 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. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A17 Adopted as Amended [D-350.983])

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask that our AMA 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 16
(I-18)

Introduced by: Region 6, Region 7; Matthew Steiner, Northeast Ohio Medical University

Subject: Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations

Referred to: MSS Reference Committee (Lauren Engel, Chair)

Whereas, Professional medical associations serve patients by improving physician knowledge and skill, engaging in scholarly activity, and working to promote the public health;[1.] and

Whereas, Patient advocacy groups provide education, outreach, and support services to patients affected by a medical condition; [2.]and

Whereas, An institutional conflict of interest occurs when the institution's secondary interests, such as financial gain, can influence decision-making relating to the organization's primary interests, such as promotion of the public health;[2.] and

Whereas, The definition of conflict of interest affirms that the conflict occurs once the two parties enter a financial or social agreement, not when a behavioral outcome from their relationship becomes known;[3] and

Whereas, A 2017 study of patient advocacy groups published in the New England Journal of Medicine revealed that disclosure practices of funding sources and amounts, uses of funding, and corporate connections of management were inconsistent;[4.] and

Whereas, The same 2017 study showed 83% of the studied patient advocacy groups received financial support from drug and biotechnology companies and at least 39% had a current or former industry executive on the governing board, leading to sources of conflict of interest;[4] and

Whereas, Professional medical associations are also susceptible to conflict of interest as they depend on industry funding for a significant portion of their operating budget, ranging from 25% to 75% of funding from drug and device companies;[5,6] and

Whereas, This reliance on funding can cause leadership of both patient advocacy groups and professional medical associations to unconsciously make decisions that favor companies that have contributed;[2,5] and

Whereas, The National Academy of Medicine in a 2009 report recommended a limiting the authors of clinical guidelines with industry financial ties to less than 50%, but this recommendation has not always been effective;[7] and

Whereas, In 2013 the American Heart Association and American College of Cardiology came under scrutiny for a prevention guideline written by many authors who had current relationships with industry or did not disclose prior industry relationships when joining the guideline panel;[7] and

Whereas, Patient advocacy groups suffering from conflicts of interest may advocate for drugs to enter the marketplace quickly or advocate for insurance coverage of these drugs despite minimal or no benefits;[2] and

Whereas, Though the 2009 Institute of Medicine report on conflict of interest recommended a disclosure law to cover industry payments to patient advocacy groups and professional medical associations, such a provision was not included in the Physician Payments Sunshine Act of 2010;[4] and

Whereas, In 2009 the American Academy of Family Physicians (AAFP) received a large sum of money from the Coca Cola corporation to fund public education on obesity and denied conflict of interest by arguing that the accusation is premature and that the Coca Cola corporation is not innately evil;[3] and

Whereas, The AAFP's public health interest directly conflicted with the Coca Cola corporation's;[3] and

Whereas, Disclosure allows the public to know all financial relationships that a physician, physician organization, or professional medical organization has with industry and weigh their influence on the organization's practices;[5] and

Whereas, the AMA Medical Code of Ethics 11.2.1 and 11.2.4 address transparency of individual physicians in healthcare settings, however they do not encompass collective transparency beyond the healthcare setting of professional medical associations and patient advocacy organizations; therefore be it

RESOLVED, That our AMA encourage the disclosure of funding sources and relationships with industry and commercial stakeholders of professional medical associations and patient advocacy organizations.

Fiscal note: Moderate, 10

Date received: 09/23/18

References:

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RELEVANT AMA AND AMA-MSS POLICY:

11.2.4 Transparency in Health Care

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives; and formularies, guidelines or other tools that influence treatment recommendations and care. Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities may have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians share in this responsibility.

Individually, physicians should:
(a) Disclose any financial and other factors that could affect the patient's care.
(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.
(c) Encourage patients to be aware of the provisions of their health plan.
Collectively, physicians should advocate that health plans with which they contract disclose to

patient-members:
(d) Plan provisions that limit care, such as formularies or constraints on referrals.
(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.
(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians' treatment recommendations.

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.

9.6.2 Gifts to Physicians from Industry

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear

effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations.

(b) Decline any gifts for which reciprocity is expected or implied.

(c) Accept an in-kind gift for the physician's practice only when the gift:

(i) will directly benefit patients, including patient education; and

(ii) is of minimal value.

(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:

(i) the program identifies recipients based on independent institutional criteria; and

(ii) funds are distributed to recipients without specific attribution to sponsors.

Principles on Corporate Relationships G-630.040
The House of Delegates adopts the following revised principles on Corporate Relationships. The Board will review them annually and, if necessary, make recommendations for revisions to be presented to the House of Delegates.

(1) GUIDELINES FOR AMA CORPORATE RELATIONSHIPS. Principles to guide AMA's relationships with corporate America were adopted by our AMA House of Delegates at its December 1997 meeting and slightly modified at the June 1998 meeting. Subsequently, they have been edited to reflect the recommendations from the Task Force on Association/Corporate Relations, including among its members experts external to our AMA. Minor edits were also adopted in 2002. The following principles are based on the premise that in certain circumstances, our AMA should participate in corporate arrangements when guidelines are met, which can further our AMA's core strategic focus, retain AMA's independence, avoid conflicts of interest, and guard our professional values.

(2) OVERVIEW OF PRINCIPLES. The AMA's principles to guide corporate relationships have been organized into the following categories: General Principles that apply to most situations; Special Guidelines that deal with specific issues and concerns; Organizational Review that outlines the roles and responsibilities of the Board of Trustees, AMA Management and other staff units. These guidelines should be reviewed over time to assure their continued relevance to the policies and operations of our AMA and to our business environment. The principles should serve as a starting point for anyone reviewing or developing AMA's relationships with outside groups.

(3) GENERAL PRINCIPLES. Our AMA's vision and values statement and strategic focus should provide guidance for externally funded relationships. Relations that are not motivated by the association's mission threaten our AMA's ability to provide representation and leadership for the profession.

(a) Our AMA's vision and values and strategic focus ultimately must determine whether a proposed relationship is appropriate for our AMA. Our AMA should not have relationships with organizations or industries whose principles, policies or actions obviously conflict with our AMA's vision and values. For example, relationships with producers of products that harm the public health (e.g., tobacco) are not appropriate for our AMA. Our AMA will proactively choose its priorities for external relationships and collaborate in those that fulfill these priorities.

(b) The relationship must preserve or promote trust in our AMA and the medical profession. To be effective, medical professionalism requires the public's trust. Corporate relationships that could undermine the public's trust in our AMA or the profession are not acceptable. For example, no relationship should raise questions about the scientific content of our AMA's health information publications, AMA's advocacy on public health issues, or the truthfulness of its public statements.

(c) The relationship must maintain our AMA's objectivity with respect to health issues. Our AMA accepts funds or royalties from external organizations only if acceptance does not pose a conflict of interest and in no way impacts the objectivity of the association, its members, activities, programs, or employees. For example, exclusive relationships with manufacturers of health-related products marketed to the public could impair our AMA's objectivity in promoting the health of America. Our AMA's objectivity with respect to health issues should not be biased by external relationships.

(d) The activity must provide benefit to the public's health, patients' care, or physicians' practice. Public education campaigns and programs for AMA or Federation members are potentially of significant benefit. Corporate-supported programs that provide financial benefits to our AMA but no significant benefit to the public or direct professional benefits to AMA or Federation members are not acceptable. In the case of member benefits, external relations must not detract from AMA's professionalism.

(4) SPECIAL GUIDELINES. The following guidelines address a number of special situations where our AMA cannot utilize external funding. There are specific guidelines already in place regarding advertising in publications.

(a) Our AMA will provide health and medical information, but should not involve itself in the production, sale, or marketing to consumers of products that claim a health benefit. Marketing health-related products (e.g., pharmaceuticals, home health care products) undermines our AMA's objectivity and diminishes its role in representing healthcare values and educating the public about their health and healthcare.

(b) Activities should be funded from multiple sources whenever possible. Activities funded from a single external source are at greater risk for inappropriate influence from the supporter or the perception of it, which may be equally damaging. For example, funding for a patient education brochure should be done with multiple sponsors if possible. For the purposes of this guideline, funding from several companies, but each from a different and non-competing industry category (e.g., one pharmaceutical manufacturer and one health insurance provider), does not constitute multiple-source funding. Our AMA recognizes that for some activities the benefits may be so great, the harms so minimal, and the prospects for developing multiple sources of funding so unlikely that single-source funding is a reasonable option. Even so, funding exclusivity must be limited to program only (e.g., asthma conference) and shall not extend to a therapeutic category (e.g., asthma). The Board should review single-sponsored activities prior to implementation to ensure that: (i) reasonable attempts have been made to locate additional sources of funds (for example, issuing an open request for proposals to companies in the category); and (ii) the expected benefits of the project merit the additional risk to our AMA of accepting single-source funding. In all cases of single-source funding, our AMA will guard against conflict of interest.

(c) The relationship must preserve AMA's control over any projects and products bearing our AMA name or logo. Our AMA retains editorial control over any information produced as part of a corporate/externally funded arrangement. When an AMA program receives external financial support, our AMA must remain in control of its name, logo, and AMA content, and must approve all marketing materials to ensure that the message is congruent with our AMA's vision and values. A statement regarding AMA editorial control as well as the name(s) of the program's supporter(s) must appear in all public materials describing the program and in all educational materials produced by the program. (This principle is intended to apply only to those situations where an outside entity requests our AMA to put its name on products produced by the outside entity, and not to those situations where our AMA only licenses its own products for use in conjunction with another entity's products.)

(d) Relationships must not permit or encourage influence by the corporate partner on our AMA. An AMA corporate relationship must not permit influence by the corporate partner on AMA policies, priorities, and actions. For example, agreements stipulating access by corporate partners to the House of Delegates or access to AMA leadership would be of concern. Additionally, relationships that appear to be acceptable when viewed alone may become unacceptable when viewed in light of other existing or proposed activities.

(e) Participation in a sponsorship program does not imply AMA's endorsement of an entity or its policies. Participation in sponsorship of an AMA program does not imply AMA approval of that corporation's general policies, nor does it imply that our AMA will exert any influence to advance the corporation's interests outside the substance of the arrangement itself. Our AMA's name and logo should not be used in a manner that would express or imply an AMA endorsement of the corporation, its policies and/or its products.

(f) To remove any appearance of undue influence on the affairs of our AMA, our AMA should not depend on funding from corporate relationships for core governance activities.
Funding core governance activities from corporate sponsors, i.e., the financial support for conduct of the House of Delegates, the Board of Trustees and Council meetings could make our AMA become dependent on external funding for its existence or could allow a supporter, or group of supporters, to have undue influence on the affairs of our AMA.

(g) Funds from corporate relationships must not be used to support political advocacy activities. A full and effective separation should exist, as it currently does, between political activities and corporate funding. Our AMA should not advocate for a particular issue because it has received funding from an interested corporation. Public concern would be heightened if it appeared that our AMA's advocacy agenda was influenced by corporate funding.

(5) ORGANIZATIONAL REVIEW. Every proposal for an AMA corporate relationship must be thoroughly screened prior to staff implementation. AMA activities that meet certain criteria requiring further review are forwarded to a committee of the Board of Trustees for a heightened level of scrutiny.

(a) As part of its annual report on the AMA?s performance, activities, and status, the Board of Trustees will present a summary of the AMA?s corporate arrangements to the House of Delegates at each Annual Meeting.

(b) Every new AMA Corporate relationship must be approved by the Board of Trustees, or through a procedure adopted by the Board. Specific procedures and policies regarding Board review are as follows: (i) The Board routinely should be informed of all AMA corporate relationships; (ii) Upon request of two dissenting members of the CRT, any dissenting votes within the CRT, and instances when the CRT and the Board committee differ in the disposition of a proposal, are brought to the attention of the full Board; (iii) All externally supported corporate activities directed to the public should receive Board review and approval; (iv) All activities that have support from only one corporation except patient materials linked to CME, within an industry should either be in compliance with ACCME guidelines or receive Board review; and (f) All relationships where our AMA takes on a risk of substantial financial penalties for cancellation should receive Board review prior to enactment.

(c) The Executive Vice President is responsible for the review and implementation of each specific arrangement according to the previously described principles. The Executive Vice

President is responsible for obtaining the Board of Trustees authorization for externally funded arrangements that have an economic and/or policy impact on our AMA.

(d) The Corporate Review Team reviews corporate arrangements to ensure consistency with the principles and guidelines. (i) The Corporate Review Team is the internal, cross-organizational group that is charged with the review of all activities that associate the AMA's name and logo with that of another entity and/or with external funding. (ii) The Review process is structured to specifically address issues pertaining to AMA's policy, ethics, business practices, corporate identity, reputation and due diligence. Written procedures formalize the committee's process for review of corporate arrangements. (iii) All activities placed on the Corporate Review Team agenda have had the senior manager's review and consent, and following CRT approval will continue to require the routine approvals of the Office of Finance and Office of the General Counsel. (iv) The Corporate Review Team reports its findings and recommendations directly to a committee of the Board.

(e) Our AMA's Office of Risk Management in consultation with the Office of the General Counsel will review and approve all marketing materials that are prepared by others for use in the U.S. and that bear our AMA's name and/or corporate identity. All marketing materials will be reviewed for appropriate use of AMA's logos and trademarks, perception of implied endorsement of the external entity's policies or products, unsubstantiated claims, misleading, exaggerated or false claims, and reference to appropriate documentation when claims are made. In the instance of international publishing of JAMA and the Archives, our AMA will require review and approval of representative marketing materials by the editor of each international edition in compliance with these principles and guidelines.

(6) ORGANIZATIONAL CULTURE AND ITS INFLUENCE ON EXTERNALLY FUNDED PROGRAMS.

(a) Organizational culture has a profound impact on whether and how AMA corporate relationships are pursued. AMA activities reflect on all physicians. Moreover, all physicians are represented to some extent by AMA actions. Thus, our AMA must act as the professional representative for all physicians, and not merely as an advocacy group or club for AMA members.

(b) As a professional organization, our AMA operates with a higher level of purpose representing the ideals of medicine. Nevertheless, non-profit associations today do require the generation of non-dues revenues. Our AMA should set goals that do not create an undue expectation to raise increasing amounts of money. Such financial pressures can provide an incentive to evade, minimize, or overlook guidelines for fundraising through external sources.

(c) Every staff member in the association must be accountable to explicit ethical standards that are derived from the vision, values, and focus areas of the Association. In turn, leaders of our AMA must recognize the critical role the organization plays as the sole nationally representative

professional association for medicine in America. AMA leaders must make programmatic choices that reflect a commitment to professional values and the core organizational purpose.

Preservation of Political Advocacy by Nonprofit Organizations H-270.968
The AMA continues to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 17
(I-18)

Introduced by: Region 6; Eric Hirsch, Cindy Tsui, SUNY Downstate College of Medicine; Tabitha Moses, Wayne State School of Medicine

Subject: Supporting Research into the Therapeutic Potential of Psychedelics

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Psychedelics are a class of drugs that produce mind-altering states, which includes psilocybin, lysergic acid diethylamide (LSD), and mescaline[1]; and

Whereas, Between 1950-1965, research into the therapeutic effects of psychedelics produced over 1,000 scientific papers and six international conferences, with promising results for alcoholism, depression, and a variety of other mental disorders[1]; and

Whereas, In the late 1960s, this promising research was halted when the FDA scheduled psychedelics as Schedule 1 drugs, due to both the dangers associated with their unregulated use and their association with the “counterculture” movement[1]; and

Whereas, There has been a recent resurgence of interest in the therapeutic application of psychedelics for patients with depression, anxiety, addiction, and a host of other psychiatric conditions[1]; and

Whereas, Despite their reported dangers in unregulated situations, such as accidental traumatic injuries, psychedelics have proven to be notably safe when administered in a regulated environment, with no long-term physical effects, tissue toxicity, or interference with liver function; scant drug–drug interaction[2]; and limited addictive properties[2-4]; and

Whereas, Studies have reported subjects who experience acute negative emotions after psychedelic use (paranoia, anxiety, etc), these emotions are short lasting and rarer in incidence than positive emotions[5]; and

Whereas, There is little evidence of adverse effects of psychedelics in habitual users, who use more often and use at a larger dose than experimental studies, and as of now, no evidence of persistent perceptual disturbances, known as ‘hallucinogen persisting perceptual disorder’ (HPPD)[5]; and

Whereas, A large population study in the USA found no link between the use of psychedelics and any mental health problems[6]; and

Whereas, The therapeutic index (TI) of both LSD and psilocybin is at least 1000, which is notably higher than that of morphine (TI = 70) and alcohol (TI = 10)[7,8]; and

Whereas, A number of prominent researchers and physicians have spoken out in support of expanding research on psychedelics[9]; and

Whereas, LSD led to a 22% reduction in STAI (State-Trait Anxiety Inventory) state anxiety at 2 months in patients with a life-threatening illness, and reductions was sustained through 12 months[10]; and

Whereas, Psilocybin has been associated with a 55% reduction in Beck Depression Inventory (BDI) scores at 3 months in patients with Major Depressive Disorder, remission of depression by BDI in 60-80% of patients with life-threatening cancer at 6.5 months, a 44% reduction in Yale-Brown Obsessive Compulsive score at 24 hours in patients with Obsessive-Compulsive disorder, a 80% abstinence rate at 6 months for smoking cessation and a 68% reduction in heavy drinking at 13-24 weeks for treatment of substance use disorders[11-15]; and

Whereas, In a randomized double-blind study of 51 participants with anxiety and depression associated with life-threatening cancer, a one-time psilocybin administration with guided therapy resulted in a 50% reduction in symptoms at 6 months post treatment in 78% of patients for anxiety, and 83% of patients for depression[16]; and

Whereas, Phase 2 trials testing MDMA with 107 participants with PTSD, 56% no longer qualified for PTSD after treatment with MDMA-assisted psychotherapy, and 12-months later, 68% no longer had PTSD[17]; and

Whereas, The current classification of psychedelic compounds as Schedule 1 means that their use is prohibited except for very limited scientific research studies requiring an extensive and costly approval process,[4,6]; and

Whereas, Drugs are considered Schedule 1 if it they meet three criteria: first, the drug or other substance has a high potential for abuse; second, the drug or other substance has no currently accepted medical use in the United States; and third, there is a lack of accepted safety for use of the drug or other substance under medical supervision[4]; and

Whereas, Current AMA policies regarding the regulation of “psychoactive” and “psychotropic” drugs only emphasize the health risks associated with such drugs and do not address the previously stated contemporary research showing their therapeutic potential, their limited addictive risk, and their limited risk when delivered in a controlled, regulated environment[1-17] (H-95.940); and

Whereas, Our AMA already has policy encouraging rescheduling of and research into other pharmaceuticals such as cannabis and cannabinoids (H-120.926 and H-95.92); therefore be it

RESOLVED, That our AMA calls for the status of psychedelics as Schedule 1 substances to be reviewed with the goal of facilitating clinical research and developing psychedelic-based medicines; and be it further

RESOLVED, That, given the high regulatory and cultural barriers, our AMA explicitly supports and promotes research into the therapeutic potential of psychedelics to help make a more conducive environment for research; and be it further

RESOLVED, That our AMA supports and promotes research to determine the consequences of long-term psychedelic use.

Fiscal Note: Significant, 11

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Expedited Prescription Cannabidiol Drug Rescheduling H-120.926

Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; and (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should

include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.

4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.

5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

Harm Reduction Through Addiction Treatment H-95.956

Our AMA urged “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.”

Emerging Drugs of Abuse are a Public Health Threat D-95.970

Our AMA committed to participating “as a stakeholder in a Centers for Disease Control and Prevention/U.S. Drug Enforcement Administration (CDC/DEA) task force for the development of a national forum for discussion of new psychoactive substances (NPS)-related issues.”

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 18
(I-18)

Introduced by: Region 5; Region 6; Ryan Chiu, University of Illinois College of Medicine

Subject: Opposing Mandated Reporting of People Who Question Their Gender Identity

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Transgender and gender nonconforming people are defined by the American Psychological Association as those who have a gender identity that is not fully aligned with their sex assigned at birth;[1] and

Whereas, An estimated 153,300 of the US population age 13-17 years old and 700,000 of US adults identify as transgender or gender nonconforming;[2] and

Whereas, Compelled disclosure policies, including, but not limited to, “mandatory reporting laws,” represent a growing effort by federal, state, and institutional agencies to increase transparency regarding abuses against vulnerable populations in hopes of preventing further abuses or harm;[3] and

Whereas, 48 states have statutes requiring specific professionals such as teachers, physicians, and counsellors to report child maltreatment to an appropriate agency;[4] and

Whereas, Judicial precedent surrounding the constitutionality of compelled speech requires that the government must be able to demonstrate a compelling state interest in the speech to be compelled;[5] and

Whereas, Ohio Representatives Brinkman and Zeltwanger, when testifying as proponents for House Bill 658, state that “Our legislation makes clear that all government entities—including schools, courts, hospitals, and child placement agencies—must inform all parents or guardians when a child expresses symptoms of gender dysphoria and obtain permission before engaging in any gender dysphoria treatment, program, or therapy,” which places explicit burden on educational and healthcare professionals to ascertain parental information and consent before pursuing any therapeutic options for these gender nonconforming minor patients;[6] and

Whereas, Ohio SB 658 would also “prohibit courts from making custody decisions based on a parent’s refusal to let a child undergo gender-based medical treatment,” which was included in opposition to a case where the custody of a teenager who identified as transgender was given to their grandparents because the parents’ refusal to allow treatment related to transitioning left the teen suicidal;[7] and

Whereas, The proposed bill in Delaware would amend Code 225, regarding Prohibition of Discrimination in educational programs and activities, so that students would require permission from the parent before accommodating any student request to recognize a change in any protected characteristic;[8] and

Whereas, The amendment in Delaware includes gender identity/expression as a protected characteristic which in turn necessitates outing the student to parents before allowing any accommodations concordant with the student's gender identity/expression;[8] and

Whereas, Laws enacted in multiple states have been upheld in court which found that parents have no right to choose a harmful treatment for their child and free speech could be regulated in order to protect children from harmful or ineffective professional services;[9, 10] and

Whereas, Gender nonconformity is a major risk factor for school victimization among LGBTQ+ (lesbian, gay, bisexual, transgender, queer) youth and may also be a reason for gender nonconforming youth to seek medical or mental health services;[11, 12] and

Whereas, The two most frequent reasons for LGBTQ+ homelessness, a group that makes up approximately 40% of homeless youth, are family rejection of sexual orientation or gender identity and being forced out by parents because of sexual orientation or gender identity;[13] and

Whereas, Young LGBTQ+ adults who reported family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse;[14] and

Whereas, 61% of LGBTQ+ youth report being out at school and 40% of high school youth report that they are out to teachers;[15] and

Whereas, 26% of LGBTQ+ youth do not want to come out to teachers out of fear that those teachers might then tell their parents and fear that it would impact their education unnecessarily;[15] and

Whereas, Pursuant to existing AMA policy H-315.983, our AMA believes "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,"; therefore be it

RESOLVED, That our AMA oppose legislation that would mandate reporting youth who question or express interest in exploring their gender identity; and be it further

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

Fiscal note: Significant, 10

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY

2.2.2 Confidential Health Care for Minors

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

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

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

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

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

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

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

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

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

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

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

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

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

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.

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.

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; (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; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

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.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Nondiscriminatory Policy for the Health Care Needs of LGBTQ 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.

Confidential Health Services for Adolescents H-60.965
Our AMA:

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

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

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

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

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

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

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

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

(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.

65.002MSS Nondiscrimination Based on Sexual Orientation
AMA-MSS continues to support its positions that nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice.

(AMA Res 12, A-89 Adopted [H-295.969]) (Reaffirmed: MSS Rep D, I-99) (Modified: MSS GC Rep A, I-16)

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]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

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)

65.015MSS Reducing Suicide Risk among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth through Collaboration with Allied Organizations
AMA-MSS will ask the AMA to partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. (MSS Res 24, A-11) (AMA Res 402, A-12 Adopted [H-60.927]) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 19
(I-18)

Introduced by: Region 1; Region 3; Region 7

Subject: Support for Universal Basic Income Pilot Studies

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The United States Office of Disease Prevention and Health Promotion recognizes economic stability as a social determinant of health[1]; and

Whereas, The poverty rate in the United States has ranged from 11 to 15% over the past 50 years and, in 2016, over 95 million Americans lived below 200% of the poverty line[2]; and

Whereas, There is a breadth of research that shows that people with poverty-level income have shorter life expectancies, increased rates of disease, decreased access to health care, and fewer necessary resources including clean water, nutritional food, and safe neighborhoods[3-7]; and

Whereas, Universal Basic Income would eliminate poverty by providing every citizen over the age of 18, regardless of income, with enough income to live just above the poverty line[8-9]; and

Whereas, Racial disparities have historically been, and continue to be, a problem within need-based assistance legislation; research shows that as a state's black and latinx population rises, it is respectively five- and three-times more likely that strong sanctions and strict time limits have been imposed on their welfare populations. Similarly, it is eight- and three-times more likely that a cap will be placed on family size[10-13]; and

Whereas, The inclusive nature of Universal Basic Income would simplify the welfare system by consolidating current non-healthcare related assistance programs and implementing a framework in which racial and other disparities are either mitigated or eliminated entirely[14]; and

Whereas, Universal Basic Income could protect workers from the harms of future technological job elimination. It is estimated that currently demonstrated technology has the capability to automate 45% of tasks workers are paid to perform and that this technology will automate a significant portion of US jobs in the near future[15-18]; and

Whereas, Studies show cash transfer programs have led to health and education benefits including a 8.5% reduction in hospitalizations in Manitoba, Canada; increased lung function and memory in Yucatan, Mexico; decreased incidence of psychiatric disorders and alcohol use among Cherokee Native Americans; and increased educational attainment under the Negative Income Tax programs in both Canada and the United States[19-25]; conversely, these programs did not have a significant negative impact on employment[26-28]; and

Whereas, Government or private-sponsored Universal Basic Income pilot programs are ongoing or scheduled to be conducted in Finland, Canada, Spain, Scotland, Kenya, and California in

order to determine the effects of Universal Basic Income including poverty reduction, better health outcomes, and improved quality of life and opportunities for recipients[25,29-34]; and

Whereas, The 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" (440.063MSS, Recognizing Poverty-Level Wages as a Social Determinant of Health) and "supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches" (440.048MSS, Eradicating Homelessness); and

Whereas, The AMA considers social determinants of health to be a significant predictor of health outcomes, supports their inclusion in the medical school curriculum (H-295.874, Educating Medical Students in the Social Determinants of Health and Cultural Competence), and encourages screening for these determinants to improve patient care (H-160.909, Poverty Screening as a Clinical Tool for Improving Health Outcomes); and

Whereas, The AMA supports evidence-based policy, and pilot studies will expand current knowledge on the potential health benefits of Universal Basic Income programs; therefore be it

RESOLVED, That our AMA supports federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants.

Fiscal Note: Moderate, 10

Date Received: 09/23/18

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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 SDH and cultural competence across the undergraduate medical school curriculum to assure that graduating B of T Rep. 39-A-18 -- page 4 of 6 1 medical students are well prepared to provide their patients safe, high quality and patient-centered care; (2) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of SDH and cultural competence in the undergraduate medical school curriculum; and (3) Recommends studying the integration of SDH and cultural competence training in graduate and continuing medical education and publicizing successful models. CME Rep. 11, A-06 Reaffirmation A-11 Modified in lieu of Res. 908, I-14 Reaffirmed in lieu of Res. 306, A-15 Reaffirmed: BOT Rep. 39, A-18

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 Reaffirmed: BOT Rep. 39, A-18

Giving States New Options to Improve Coverage for the Poor D-165.966
Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; and (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons. Res. 118, A-04 Reaffirmed: CMS Rep. 1, A-05 Modified: CMS Rep. 8, A-08 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed: CMS Rep. 5, I-11

Regulatory Standards Should be Evidence-Based H-220.930
Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be appended to the documentation for every clinical standard imposed on health care institutions and providers. Res. 727, A-10 Reaffirmed: BOT Rep. 7, A-11

Evidence-Based Standard Requirement for Governmental Regulation H-270.956
Our AMA supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded. BOT Rep. 7, A-11

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
2. Our AMA will advocate to the federal government - including responding to the Food

and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria. Res. 424, A-10

Recognizing Poverty-Level Wages as a Social Determinant of Health 440.063MSS
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

Eradicating Homelessness 440.048MSS
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) support the appropriate organizations in developing an effective national plan to eradicate homelessness. MSS Res 33, A-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 20
(I-18)

Introduced by: Region 6

Subject: Increasing Transparency in Food Labeling Regarding Food Products Contributing to Metabolic Syndrome

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Obesity is defined as a Body Mass Index (BMI) 30kg/m2 or greater, and has been linked to several medical and psychiatric comorbidities, including metabolic syndrome, depression, anxiety, and binge eating disorders1,2; and

Whereas, 40% of American adults live with obesity and 30% meet criteria for metabolic syndrome3,8; and

Whereas, Obesity is a contributing factor to heart disease, stroke, diabetes and kidney disease, which are all top ten causes of death in the US4; and

Whereas, Rates of childhood obesity in the US increase with age, from 12.4% in kindergarten to 20.8% in eighth grade, and food habits which youth develop are often carried with them into their adult lives5; and

Whereas, low cost, energy dense, hyper-palatable food products high in saturated fat, sugar, and sodium are widespread in the US food environment, contributing to obesity and metabolic syndrome6; and

Whereas, Hyper-palatable food products have been shown to activate neuronal pathways associated with reward and substance use7; and

Whereas, Disparities exist in obesity rates by income status, race and ethnic minorities, and our AMA has policies which oppose targeted advertising of unhealthy food products to youth and particularly vulnerable populations such as minority and low income youth (H-60.972); and

Whereas, Existing AMA-MSS policies support decreasing the availability of sugar added beverages in hospitals and schools (215.004MSS, 150.017MSS); and

Whereas, Our AMA has policies which support among other strategies, taxation, warning labels on unhealthy food products high in added sugar, saturated fat and sodium, (H-150.927); and

Whereas, there is no standard which defines “high” relative to the FDA recommended daily percent value of a given nutrient based on a 2,000 calorie diet from the AMA, FDA, USDA or any other organization that focuses on nutrition in the US9; and

Whereas, Mexico's 8% tax on non-essential foods with energy density >275kcal/100g resulted in a significant decrease in consumption10; and

Whereas, lobbying organizations like American Beverage Association have passed legislation banning new municipal taxation of sugar sweetened beverages until 2031 in Berkeley California11; and

Whereas, cities that have passed legislation taxing sugar sweetened beverages have seen significant declines in their consumption12; therefore be it

RESOLVED, That our AMA work with the appropriate stakeholders to advocate for the establishment of guidelines defining high-calorie, high-fat, high-sugar, and high-sodium foods based on the FDA recommended daily percent values.

Fiscal Note: Significant, 12

Date received: 09/23/2018

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Relevant AMA and AMA-MSS Policy:

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

1. Our AMA supports the adoption and implementation of a uniform, **nutritional** food **rating system** in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a **rating** scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall **nutritional** decision making.
2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition **rating system** that meets the above-referenced criteria.

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.

Taxes on Beverages with Added Sweeteners H-150.933: 1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.
4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927: Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place

of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975: Our AMA will: (1) publish an educational brief to educate physicians about the effects **of sugar-sweetened beverages** (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (**SNAP**) recipients along with the revised eligible foods and **beverages** guidelines, and (3) work to remove SSBs from **SNAP**.

Addition of Alternatives to Soft Drinks in Schools D-150.987: Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools.

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980: Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.

Banning Food Commercials Aimed at Children H-60.972: 1. It is the policy of our AMA to: (a) 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 (b) support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA, when such marketing targets youth, especially vulnerable populations. 2. Our AMA will: (a) establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; and (b) work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations.

150.017MSS Addition of Alternatives to Soft Drinks in Public Schools: AMA-MSS will ask the AMA to seek to promote the consumption and availability of low calorie, low sugar drinks as a healthy alternative in public schools instead of beverages such as carbonated sodas. (MSS Res 36, I-04) (AMA Amended Res 413, A-05 Adopted [D-150.987]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

215.004MSS Banning the Sale of Sugar-Sweetened Beverages in Hospitals: AMA-MSS supports measures that restrict retail or vending machine sales of sugar-sweetened beverages in hospitals, clinics, or food service outlets that operate in space owned by licensed health care facilities. (MSS Res 9, I-15)

150.035MSS Regulating Front-Of-Package Labels on Food Products: AMA-MSS asks that our AMA support additional FDA criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits and (2) AMA support the use of front-of-package warning labels on foods that contain excess added sugar (MSS Res 14, A-18)

150.020MSS Decreasing Incidence of Obesity and Negative Sequelae by Reducing the Cost Disparity Between Calorie-Dense, Nutrition Poor Foods and Nutrition-Dense Foods: AMA-MSS will ask the AMA to (1) support efforts to decrease the price gap between calorie dense, nutrition poor (CDNP) foods and naturally nutrition dense (ND) foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrolment, of existing programs that seek to improve nutrition and reduce obesity such as the Farmer's Market Nutrition Program (FMNP) as a part of the Women, Infants, and Children (WIC) program; and (2) support the novel application of FMNP to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of ND foods in wider food distribution venues than solely farmer's markets as part of WIC. (MSS Res 23, I-09) (AMA Res 414, A-10 Adopted [H-150.937]) (Reaffirmed: MSS GC Rep A, I-14)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 21
(I-18)

Introduced by: Samantha Lund, Washington University School of Medicine

Subject: Trauma-Informed Care Resources

Referred to: MSS Reference Committee
(Lauren Engel,Chair)

Whereas, Numerous studies since the 1998 Adverse Childhood Experiences (ACE) Study have analyzed the relationship between traumatic events and health outcomes, such as substance abuse, heart disease, depression/suicide, and sexual violence[1,2,3]; and

Whereas, Trauma is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being"[4]; and

Whereas, Over two-thirds of Americans are exposed to at least one traumatic event by the age of 16[5]; and

Whereas, Every additional traumatic event increases the risk of an adverse health outcome proportionally[1,3,6]; and

Whereas, Trauma's lasting health implications cause economic impacts, with estimates of child maltreatment costing the US economy $124 billion per year[7]; and

Whereas, If physicians and other health care providers practice trauma-informed care, adverse health outcomes, such as chronic disease and risky health behaviors, can be mitigated[1,3,6] ; and

Whereas, Trauma-informed care is the realization of trauma on patients' lives, recognition of signs of trauma, creation of safe, transparent, and supportive environments, and avoidance of re-traumatization[4]; and

Whereas, Many states and cities have attempted to address trauma and treatment in their communities by collecting data, training health care providers, and providing resources[8,9,10,11]; and

Whereas, Several prominent national organizations, such as the Centers for Disease Control and Prevention (CDC), SAMHSA, the National Child Traumatic Stress Network (NCTSN), and the National Council, have conducted research and created training tools[12,13,14,15]; and

Whereas; Existing AMA policy calls to "support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care," (H-60.929) but does not address the need for trauma-informed care in adult populations[16]; and

Whereas, There is not a centralized, evidence-based location for resources on trauma-informed care for physicians and other health care providers for patients of all ages[6,17,18]; therefore be it

RESOLVED, That our AMA will recognize trauma's impact on health outcomes and trauma-informed care's role in mitigating those effects; and be it further

RESOLVED, That our AMA will partner with existing organizations to compile evidence-based resources for physicians and other health care providers to learn about traumatic experiences, their effects on health, and trauma-informed care practices.

Fiscal Note: Moderate, 10

Date Received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

National Child Traumatic Stress Network H-60.929
Our AMA: 1) Our AMA recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by
the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant health care organizations to support full funding of
the National Child Traumatic Stress Initiative at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network.

Juvenile Justice System Reform H-60.919
1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.

4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

Legal Protection and Social Services for Commercially Sexually Exploited Youth 60.023MSS

That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (MSS Res 40, A-14) (MSS Res 4, I-14 Adopted as Amended [D-60.969])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 22
(I-18)

Introduced by: Region 6; Nina Bihani, Wayne State University School of Medicine

Subject: Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The prevalence of children living with Autism Spectrum Disorder is 1 in 59, according to the Center for Disease Control as of April 2018, and 3.5 million Americans live with Autism Spectrum Disorder today1,2; and

Whereas, Applied Behavioral Analysis is a treatment program for patients with Autism Spectrum Disorder that seeks to promote useful social and educational behaviors through a comprehensive and highly individualized plan, while reducing behaviors that would interfere with learning3,4; and

Whereas, The scientifically-proven effectiveness of Applied Behavior Analysis-based treatment programs has been well-documented through numerous studies across five decades of research, with strong empirical support that ABA is currently the most effective intervention for patients with Autism Spectrum Disorder5-7; and

Whereas, The American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics assert that Applied Behavioral Analysis therapy can produce improvements in social relationships, self-care, school, employment, communication, and play in all age groups8-10; and

Whereas, Children who receive early, intensive Applied Behavior Analysis therapy make larger improvements in social and life skills than those who are in a less intensive program, and research has shown significant improvements in Intellectual Quotient for children in Applied Behavior Analysis therapy11; and

Whereas, The Centers for Medicare and Medicaid Services require states to cover all medically necessary services for children, including services to address Autism Spectrum Disorders, but allows individual state Medicaid agencies to determine what services are medically necessary for eligible individuals12; and

Whereas, Among state mandated maximum ages of eligibility for Applied Behavior Analysis, there exists age variability: from age 5 to explicitly no age limit, and there exists insurance coverage variability: from $12,000 per year (Kentucky) to no annual or lifetime cap13; and

Whereas, Studies indicate that significant cost aversion and cost avoidance up to $208,500 per child may be possible with early implementation of the applied behavioral analysis model14; and

Whereas, The majority of the costs for Autism Spectrum Disorder treatment are in the form of adult-care, “175-196 billion [for adults], compared to $61-66 billion for children”2, and the “cost of lifelong care can be reduced by 2/3 with early diagnosis and intervention”15; and

Whereas, Existing AMA policy states that the AMA will “urge physicians to assist parents in obtaining access to appropriate individualized early intervention services” (H-90.969), and asserts that “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” (H-90.968); and

Whereas, AMA-MSS policy (25.002MSS) calls for AMA “to encourage government agencies, non-profit organizations, and specialty societies to develop policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with a goal of independent function when possible”; therefore, be it

RESOLVED, That our AMA support policy that Applied Behavioral Analysis be classified as a medical intervention, in the context of insurance billing, for the purpose of treating Autism Spectrum Disorder; and be it further

RESOLVED, That our AMA advocate for increased funding for the development of additional effective interventions for people with Autism Spectrum Disorder; and be it further

RESOLVED, That our AMA advocate for adequate and appropriate reimbursement for Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder by all public and private insurance programs.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Early Intervention for Individuals with Developmental Delay H-90.969
1. Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services.

2. Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.
CCB/CLRPD Rep. 3, A-14 Reaffirmed: Res. 315, A-17

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 comorbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

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

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

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

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

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

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

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

10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

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.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 23
(I-18)

Introduced by: Daniel Alligood, Shruti Gupta, Medical College of Georgia

Subject: Supporting life narrative services in geriatric patients

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Population demographics predict a significant increase in the U.S. geriatric population[1]; and

Whereas, Aging brings about many social and health challenges[2]; and

Whereas, One such challenge is increased geriatric suicide rates due to depression[3-4]; and

Whereas, The geriatric population undergoes unique psychosocial development, including Erikson's Theory of Psychosocial Development and Butler's life review[5-8]; and

Whereas, Erikson's Theory suggests the geriatric population undergoes the core conflict of integrity versus despair, where individuals review their life, ideally eliciting wisdom and integrity rather than regret and despair[5-6]; and

Whereas, Butler's Theory suggests life review is a psychological developmental stage described as a "universal occurrence in older people of an inner experience or mental process of reviewing one's life... that it contributes to late-life disorders, particularly depression, and that it participates in the evolution of candor, serenity, and wisdom"[7-8]; and

Whereas, Reminiscence intervention, life review intervention and life review therapy (termed "life narrative services" from here on) developed from Butler's and Erikson's Developmental Theories[8]; and

Whereas, Reminiscence intervention is typically an "unstructured autobiographical storytelling with the goal of communicating and teaching or informing others, remembering positive past events, and enhancing positive feelings"[9]; and

Whereas, Life review intervention is typically a structured analysis of one's entire life focusing "on (re-)evaluation of life events and on the integration of positive and negative life events in a coherent life story"[9]; and

Whereas, Life review therapy is a therapeutic technique, focusing "on reducing bitterness revival and boredom and promoting a positive view on one's past"[9]; and

Whereas, Life narrative services seek to guide older people through the final developmental stage with the ultimate goal of self-acceptance and psychological health[9]; and

Whereas, These services range from extensive, multi-week sessions with a trained professional, one-time sessions with a trained volunteer, group narrative review sessions lead by a trained professional/volunteer, or an online medium[8-17];

Whereas, Multiple studies have demonstrated the benefits of life narrative services for geriatric patients by either lowering depressive symptoms or improving life satisfaction[8-17]; and

Whereas, A 2012 meta-analysis of life narrative services showed that reminiscence interventions generated moderate improvements in depression (g=0.57 SD units) and that life-review therapy generated larger improvements (g=1.28)[9]; and

Whereas, A 2017 meta-analysis of life review therapy in older adults demonstrated a significant reduction in depression (standardized mean difference 0.57, 95% CI 0.73 to -0.42) and hopelessness (mean difference 4.01, 95% CI 6.13 to -1.89); and a significant improvement in well-being (SMD 0.54, 95% CI 0.01-1.06) and specific memory (MD 1.05, 95% CI 0.07-2.03)[10]; and

Whereas, A 2012 randomized control trial found the likelihood of clinically significant change in depressive symptoms was significantly higher (odds ratio = 3.77, p <0.001) for individuals who received life review therapy (n=100) compared with care as usual (n=102)[11]; and

Whereas, A 2015 randomized control trial (n=174) found that online-guided life-review reduced depressive symptoms (d=0.35) and enhanced emotional (d=0.16) psychological well-being (d=0.27) in middle-aged and older adults compared to waiting list group[12]; and

Whereas, A 2018 randomized control trial (n=74) found that individuals receiving life review therapy had a significantly increased Life Satisfaction Index compared to their baseline and to controls[13]; and

Whereas, Existing AMA policy recognizes the increased rates of suicide among the elderly due to depression and loneliness (H-25.992); and

Whereas, Existing AMA policy believes in preserving dignity and self-respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age (H-25.997); and

Whereas, Existing AMA policy supports research in medical and socioeconomic aspects of aging, geriatric training for all areas of medical education, and acceleration of ongoing efforts to address health care needs of geriatric patients (H-25.998, H-25.999, H-25.993); and

Whereas, Existing AMA policy states that our AMA will define the content, format and functionality of medical record systems (H-480.971); and

Whereas, Existing AMA-MSS policy supports "the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record (160.033MSS); therefore be it

RESOLVED, That our AMA-MSS support the efficacy of using life narrative services as a way to achieve holistic, compassionate geriatric patient care; and be it further

RESOLVED, That our AMA-MSS support the implementation of life narrative services in health care institutions; and be it further

RESOLVED, That our AMA-MSS support voluntary inclusion of the narratives in the patient's electronic medical record; and be it further

RESOLVED, That our AMA-MSS encourages physicians to integrate the voluntary use of life narrative services provided by health institutions for all geriatric patients; and be it further

RESOLVED, That our AMA-MSS encourages medicals schools to integrate life narrative services in their curriculum.

Fiscal note: Minimal, 6

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Dignity and Self Respect H-25.997
The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. Furthermore, the AMA believes in preserving dignity and self respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

Health Care for Older Patients H-25.999

The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2)

recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum.

Policy Recommendations in the Field of Aging H-25.998
It is the policy of the AMA that: (1) Older individuals should not be isolated;
(2) a health maintenance program is necessary for every individual;
(3) more persons interested in working with the older people in medical and other professional fields are needed;
(4) more adequate nursing home facilities are an urgent health need for some older people in many communities;
(5) further development of service and facilities is required;
(6) extension of research on both medical and socioeconomic aspects of **aging** is vital;
(7) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and
(8) local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.

Senior Suicide H-25.992
It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Physician Involvement in Long-Term Care H-280.999
1. Our AMA will emphasize in its communications to the medical profession, medical educators, and other professional groups concerned with long-term care the importance of increased physician understanding, supervision of, and involvement in care of the chronically ill and disabled of all ages in all care settings. The AMA believes that physicians have a central role in assuring that all residents of nursing facilities receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the resident's physical and psychosocial functioning. The AMA endorses the following "Guidelines for Physicians Attending Patients in Long-Term Care Facilities":

The Computer-Based Patient Record H-480.971
The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based **medical** information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal **medical record** system; the goal being to define the content, format and functionality of **medical record** systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer

interaction (the physician data input step) and work with software venders on the design of facile interfaces. (5) Provide guidance on the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of **electronic medical** data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient **record**.

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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 24
(I-18)

Introduced by:	Nicole Kagan, Calli Fletcher Morris, Meghna Srinath, Scott Berndt, University of Missouri School of Medicine; Samantha Lund, Washington University School of Medicine in St. Louis; Shannon Tai, Saint Louis University School of Medicine
Subject:	Reducing Maternal Tobacco Use During Pregnancy
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Smoking tobacco during pregnancy is a major public health concern with clearly established consequences such as low birth weight and increased risk of sudden infant death syndrome1; and

Whereas, Recent data shows that 1 in 14 women smoke while pregnant and in some states, the prevalence is as high as 25%2; and

Whereas, Smoking prevalence among pregnant women varies widely by race, with the highest rates among American Indian/Alaska Natives, whites, rural communities, 15-29 year-olds, and women with a high school diploma or GED2,3,4; and

Whereas, The perceived risk of smoking has decreased from 2006 to 2015, with more mothers falsely believing that smoking is safe in the first trimester of pregnancy, that complete cessation might be more harmful than cutting back, and that e-cigarettes may be safer than other forms of tobacco5,6; and

Whereas, Though little research has been conducted on e-cigarette effects on health, there is conclusive evidence that e-cigarettes do contain toxic materials and the American College of Obstetricians and Gynecologists recommends pregnant women be informed about associated risks for the mother and developing fetus6,7; and

Whereas, 72% of adults have mobile phones with SMS texting and 64% have smartphones that could allow easy access to educational materials and smoking cessation resources for pregnant women, especially women who are younger or lower socioeconomic status8; and

Whereas, Although, mobile platforms offer several notable advantages including reach and accessibility to a wider population at little or no cost, increased privacy for participants, and resources easily accessible to users beyond clinical visits, they have been largely underutilized in efforts to improve smoking cessation during pregnancy8,9,10,11; and

Whereas, Existing AMA policy H-420.976, “Alcohol and Other Substance Abuse During Pregnancy,” calls for our AMA to support ongoing efforts to educate the public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal

development and favors expanding these efforts to target abuse of other substances; therefore, be it

RESOLVED, That our AMA promote educational campaigns that emphasize the harmful effects of smoking, including e-cigarettes, on prenatal and postnatal development, specifically targeting states with the highest prevalence of smoking during pregnancy, rural communities and other high-risk groups; and be it further

RESOLVED, That our AMA support the creation and utilization of mobile platforms to increase access to educational materials and smoking cessation resources for pregnant women.

Fiscal note: Significant, 10

Date received: 09/01/18

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RELEVANT AMA AND AMA-MSS POLICY:

Alcohol and Other Substance Abuse During Pregnancy H-420.976
Our AMA: (1) supports ongoing efforts to educate the public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal development; (2) favors expanding these efforts to target abuse of other substances; and (3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities.

Drug Abuse in the United States – the Next Generation H-95.976
Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;

(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;

(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;

(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;

(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;

(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;

(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and

(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

Fetal Effects of Maternal Alcohol Use H-420.991
The AMA believes that (1) The evidence is clear that a woman who drinks heavily during pregnancy places her unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse and alcoholism in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group.
(2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent.
(3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence.
(4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake.
(5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations.
(6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal drinking that are less dramatic and pronounced than are features of the fetal **alcohol** syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations.

Warnings Against Alcohol Use During Pregnancy H-420.974
Our AMA urges pharmaceutical companies that manufacture over-the-counter pregnancy and ovulation tests and related products to include written or pictorial warnings against alcohol, tobacco and illicit drug use during pregnancy in their package inserts.

Comprehensive Health Education H-170.977
(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.

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 inter-conception 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.
Physician Responsibilities for Tobacco Cessation H-490.917
Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:

(1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;

(2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;

(3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;

(4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician;

(5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs;

(6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and

(7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any

individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 25
(I-18)

Introduced by: Kevin MacKrell, Neha Anand, Ved Tanavde, Ben Bigelow, Megan Hunt, Kori Porosnicu Rodriguez, Laura Pugh, Annie Cho, Johns Hopkins University; Jessica Lee, University of Maryland School of Medicine;

Subject: Gun Violence and Mental Illness Stigma in the Media

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, In the wake of recent mass shootings, there have been statements in the media about mental health and gun violence, with examples including "(1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control "won't prevent" another Newtown (Connecticut school mass shooting)";[1] and

Whereas, Between 2005-2014, an analysis of a sample of national news stories about mental illness showed that 56% of stories mentioned violence related to mental illness and of those stories, 75% detailed a specific violent event by a person with mental illness - most often a gun violence event (32%) or a mass shooting event (22%);[2] and

Whereas, News media portrayals of mass shooting events that describe the shooter as having serious mental illness increase people's negative attitudes toward those with serious mental illness, heightening desired social distance from and perceived dangerousness of those with serious mental illness;[3] and

Whereas, A 2013 Gallup poll showed that 80% of adult Americans placed blame ("a great deal" and "a fair amount" of blame) on the mental health system for mass shootings, while around 40% blamed easy access to guns, showing the responsibility that we have to clarify the statistics surrounding mass shootings for the knowledge of the general public;[4] and

Whereas, A 2017 CBS poll found that 68% of Americans believe that better mental health screening could help prevent gun violence a lot;[5] and

Whereas, Experts on gun violence rank other measures to reduce mass shootings, such as a banning assault weapons and universal background checks, as more effective than expanding mental health treatment;[6] and

Whereas, Mental health care spending, mental health professionals per capita, and the rate of severe mental health disorders is not higher in the US compared to other developed countries, which have lower rates of mass shootings;[7] and

Whereas, "Most people who are violent are not mentally ill, and most people who are mentally ill are not violent";[8] and

Whereas, The National Center for Health Statistics indicate that fewer than 5% of the 120 000 gun-related killings in the United States between 2001 and 2010 were perpetrated by people diagnosed with mental illness;[9] and

Whereas, Mass shootings by people with serious mental illness represent less than 1% of all yearly gun-related homicides; in contrast, deaths by suicide using firearms account for nearly two-thirds of yearly gun-related deaths, or 20,000 deaths per year;[10] and

Whereas, There is little evidence to support that those diagnosed with mental illness are more likely than anyone else to commit a crime with a gun;[1] and

Whereas, Substance use, substance use with comorbid serious mental illness, a parental history of abuse and/or neglect, and binge drinking more strongly correlate with violence/gun violence than mental illness alone;[11] and

Whereas, Although some mass shooters are found to have a history of psychiatric illness, no reliable research has suggested that a majority of perpetrators are primarily influenced by serious mental illness;[10] and

Whereas, "Higher rates of firearm ownership are associated with higher rates of overall suicide and firearm suicide"; [12] and

Whereas, Stigma towards mental health can be structurally incorporated into legislation, such as gun laws that restrict firearm privileges "targeting people with mental illness per se rather than people who are incompetent as a result of having a mental illness";[13] and

Whereas, Stigma toward those with mental illness, including a perception that they are dangerous or aggressive, may deter patients from seeking health care;[14] and

Whereas, Health care professionals may harbor stigma against mental illness for the same reasons;[15] therefore be it

RESOLVED, that our AMA-MSS support that the AMA work with all appropriate specialty societies to enhance the accuracy of media reports concerning mental health and gun violence, and to reduce the stigma associated with mental illness.

Fiscal Note: Significant, 10

Date Received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

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

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

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

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 26
(I-18)

Introduced by:	Jesse Wang, University of Wisconsin School of Medicine and Public Health; Neel Nabar, Thomas Jefferson University, Sidney Kimmel Medical College; Baillie Bronner, University of New Mexico School of Medicine
Subject:	Encouraging development of physician liability guidelines in telemedicine
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Telemedicine has demonstrated significant utility in treating patients, especially those with restricted access to care, chronic diseases, or critically ill patients and telehealth services have achieved comparable or improved outcomes when compared to face-to-face visits in many clinical applications;1-3 and

Whereas, The adoption of telemedicine services among healthcare providers within US Hospitals have increased from 54% in 2014 to 71% in 20174 and the market for telemedicine technologies was approximately $29.6 billion in 2017 and is expected to grow at a compound annual growth rate of 19% between 2017 to 2022;5 and

Whereas, There were 196 medical professional liability (MPL) claims related to telephone treatment between 2004-2013 resulting in a total indemnity loss of $17 million, with the fraction of telemedicine related MPL losses expected to increase with further adoption;6 and

Whereas, There currently exist inconsistencies between states in the regulation of telemedicine such as employees within state-run health centers may not be protected under their state's tort claims act when providing telemedicine services across borders;7 and

Whereas, Professional liability policies that cover in-person services may incur a surcharge or not cover the same services when provided over telemedicine such as intraoperative surgical monitoring and remote diagnosis in teleradiology;7-11 and

Whereas, AMA policy H-480.974 and H-480.9we46 calls for our AMA to work with Federation of State Medical Boards and the American Telemedicine Association to develop practice and technical guidelines for telemedicine, but it does not explicitly address issues surrounding liability; therefore, be it

RESOLVED, That our AMA amend policy H-480.974.8, Evolving Impact of Telemedicine, by addition as follows

> Our AMA will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure and liability

guidelines for telemedicine practiced across state boundaries; and be it further

RESOLVED, That our AMA amend policy H-480.946.7, Coverage of and Payment for Telemedicine, by addition as follows:

H-480.946.7, Coverage of and Payment for Telemedicine

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 and liability standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Fiscal note: Minimal, 6

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Quantifying Medical Tort Reform H 435.10MSS
AMA-MSS supports medical liability reform at the federal, state, and municipal levels including, but not limited to, non-economic damage caps, collateral source offset provisions, and the implementation of malpractice courts; (2) AMA-MSS will ask the AMA to study the true costs of

defensive medicine and the financial impact that tort reform would have on the entire health care system, with a report back and to be updated every ten years.

Federal Preemption of State Professional Liability Laws H-435.964
The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.

Federal Medical Liability Reform H-435.978
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform.

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.

The Promotion of Quality Telemedicine H-480.969
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must

accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

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.

Liability Reform D-435.992
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its call for immediate legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process.

Telemedicine Encounters by Third Party Vendors D-480.968
1) Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent. 2) The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information. 3) Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) 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; and (c) The standards and scope of telemedicine services should be consistent with related in-person services. 4) Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Telemedicine H-480.968
The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 27
(I-18)

Introduced by:	Region 2; Region 5; Halea Meese, University of Colorado School of Medicine
Subject:	Increasing the Availability of Bleeding Control Supplies
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Injury is the leading cause of death for people ages 1-44 in the United States1 and severe bleeding accounts for greater than 33% of prehospital trauma deaths;2 and

Whereas, The most significant preventable cause of death in the prehospital environment is external hemorrhage;3 and

Whereas, Bystanders play an important role in bleeding control as average national EMS response times are longer than the time it can take for individuals to die from exsanguination;4 and

Whereas, As of 2018, over 124,000 members of the general public have been trained in basic bleeding control techniques by the Stop the Bleed Campaign;5 and

Whereas, Civilian prehospital tourniquet application is independently associated with a 6-fold mortality reduction in patients with peripheral vascular injuries;6 and

Whereas, The Occupational Safety and Health Administration (OSHA) standards govern requirements that must be followed by private sector and federal workers;7 and

Whereas, OSHA Appendix A to Standard 1910.151 cites (ANSI) Z308.1-1998 as an example of a workplace first aid kit, but the standard for such kits was updated in 2015 to include a more comprehensive set of hemostatic supplies, including a tourniquet;8,9 and

Whereas, OSHA standards for industries such as logging explicitly mandate the “minimally acceptable number and type of first-aid supplies for first-aid kits” but these requirements do not directly reflect the (ANSI) Z308.1-2015 standard;10 and

Whereas, our AMA has previously supported similar policy (130.935, D 470.992) on the widespread placement of AEDs in schools and other public places; and

Whereas, Trained bystanders should have immediate access to proper bleeding control supplies, such as a tourniquet and hemostatic gauze, to be most effective in controlling life-threatening bleeding;3 therefore be it

RESOLVED, That our AMA support the increased availability of bleeding control supplies including, but not limited to, hemostatic dressings, tourniquets, and gloves, in schools, places of employment, and public buildings; and be it further

RESOLVED, That our AMA support legislation promoting new public building construction projects to have widespread placement of bleeding control supplies; and be it further

RESOLVED, That our AMA encourage OSHA and other health or safety governing bodies to investigate and update their recommendations and policies concerning bleeding control supplies to reflect recent hemorrhage control research.

Fiscal note: Significant, 12

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Support for Hemorrhage Control Training H-130.935
1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control

2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets, and gloves) for all first responders

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992
Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest.

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938
Our AMA: (1) supports publicizing the importance of teaching (CPR), including the use of automated external defibrillation; (2) strongly recommends the incorporation of (CPR) classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in (CPR) and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; and (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.

First Aid Training For Child Daycare Workers 60.006MSS
AMA-MSS will ask the AMA to recommend that all licensed child daycare facilities have a minimum of one employee currently certified in first aid including adult/pediatric and infant CPR and foreign body airway management, on site and available during all business hours. (AMA Amended Res 213, I-94 Adopted [H-60.957]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I10) (H-60.957 Rescinded: CSAPH Rep. 1, A-14) (Reaffirmed: MSS GC Rep D, I-15)

MSS Use of Automatic External Defibrillators 130.002MSS
AMA-MSS will ask the AMA to support legislation for the increased use of automatic external defibrillators (AEDs) for the purpose of saving the life of another person in cardiac arrest provided that: (1) A person or entity who acquires an automatic external defibrillator ensures that: (A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer's operational guidelines; and (C) Any person who renders emergency care or treatment on a person in

cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible. (2) Any person or entity who acquires an automatic external defibrillator is encouraged to register the existence and location of the defibrillator with the emergency communications district or the ambulance dispatch center of the primary provider of emergency medical services where the automatic external defibrillator is to be located. (MSS Sub Res 12, A-98) (AMA Res 503, I-98 Referred) (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Implementation of Automated External Defibrillators in High School and College Sports Programs 270.019MSS

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 Adopted [D-470.992]) (Reaffirmed: MSS GC Report C, I-12)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 28
(I-18)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville, SC; Rishi Thaker, Touro College of Osteopathic Medicine, NY

Subject: Supporting research into the use of Mobile Integrated Health Care and Community Paramedicine in addressing the primary care shortage

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The Health Resources and Services Administration currently estimates that approximately 14,076 primary care practitioners are needed to remove the shortage from current Health Professional Shortage Areas (HPSA)6; and

Whereas, The Association of American Medical Colleges (AAMC) predicts a primary care physician shortage of between 14,800 and 49,300 physicians by 20303; and

Whereas, The National Center for Health Statistics reports that, “approximately 20% of U.S. adults seek health care at the Emergency Room (ER) each year,” and of those 7% cited a lack of access to another provider as the reason for the visit4; and

Whereas, Mobile Integrated Health Care and Community Paramedicine is a newly established division of Emergency Medical Services (EMS) that regularly visits patients with chronic diseases such as diabetes mellitus, hypertension, heart failure, and chronic obstructive pulmonary disease (COPD) in order to manage these conditions and reduce primary care and emergency room visits for these2; and

Whereas, The preliminary data from mobile integrated health care and community paramedicine pilot programs internationally and in the United States suggest an overall reduction in hospital readmissions and emergency department visits, along with reduction in medical care cost per person2; and

Whereas, Recent data from rural community paramedicine found these programs to be especially useful in underserved medical communities, where they were found to reduce systolic blood pressure numbers, blood glucose levels, and inpatient and outpatient admissions1; and

Whereas, Community paramedics possess a sufficient knowledge base to provide high-quality preventive and primary care to those with chronic medical conditions2,5; and

Whereas, There is a current lack in the research available on how impactful community paramedicine can be in addressing current health care problems5; and

Whereas, Our AMA-MSS has policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care (AMA-MSS policy 165.009MSS); and

Whereas, Our AMA-MSS has policy to work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the U.S. Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding (AMA-MSS policy 130.004MSS); therefore be it

RESOLVED, That our AMA-MSS encourage further research into mobile integrated health care and community paramedicine as a means of delivering healthcare to underserved communities and reducing the burden of the primary care shortage.

Fiscal Note: Minimal, 6

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Access to Primary Care Services H-160.951
The AMA (1) will work to assure that a patient's access to primary and principal care services provided by a physician is not limited by the specialty or subspecialty designation of the physician, but should be determined by the training, competence, and experience of the physician to provide primary or principal care services; (2) urges health plans to allow physicians with the appropriate qualifications to elect to provide primary, specialty and subspecialty care services, and to pay these physicians appropriately for the provision of such services; (3) encourages all health insurance programs, indemnity programs, HMOs and federally funded health insurance programs, such as Medicare and Medicaid, to list Med-Peds physicians who request dual listings, to include them as both adult and pediatric clinicians, and (4) urges physicians, prior to electing to provide both primary and specialty care services under

a specified health plan contract, to consider the possible economic and profiling consequences of such actions.

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
(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.

Incentive Programs to Improve Access to Care in Underserved Areas D-200.984

Overcrowding and Hospital EMS Diversion H-130.945
(1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds; (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups; (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;

Primary Care Physicians in the Inner City H-200.972

Our AMA should pursue the following plan to improve the recruitment and retention of physicians in the inner city:
(1) Encourage the creation and pilot-testing of school-based, church-based, and community-based urban "family Health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
(2) Encourage the affiliation of these family health clinics with urban medical schools and teaching hospitals.
(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.
(4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.
(5) Advocate the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.
(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.
(8) Encourage the AMA Senior Physicians Services Group to consider the use in underserved urban settings of retired physicians, with appropriate mechanisms to ensure their competence.

(9) Urge urban hospitals and medical societies to develop opportunities for physicians to work part-time to staff urban health clinics.
(10) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who serve the inner-city poor.
(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.
(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.
(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.
(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.
(15) Urge urban hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to fill gaps in urban care.
(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.
(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
(18) Continue to urge measures to enhance payment for primary care in the inner city.

Rural Health Opportunities for Medical Students 465.001MSS
AMA-MSS will ask the AMA to encourage medical schools to develop Divisions of Rural Health within their Departments of Family Practice and encourage rural physicians to help increase rural health opportunities for medical students by participating as members of the medical school academic environment. (AMA Amended Res 308, I-94 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)

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers

and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

Decreasing Emergency Department Overcrowding 130.004MSS
(1)AMA-MSS supports legislation that addresses the issue of emergency department overcrowding and patient boarding. (2) AMA-MSS will ask the AMA to work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the U.S. Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding. (MSS Sub Res 2 Adopted in Lieu of MSS Res 2 and MSS Res 7, I-08) (CMS Rep 3, A-09, Adopted in Lieu of AMA Res 719, A-09 [H-130.940]) (Reaffirmed: MSS GC Rep A, I-14)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 29
(I-18)

Introduced by: Alexander Mozeika, Rijul Asri, and Priya Kantesaria, Rutgers New Jersey Medical School; Kristan Baird, Uniformed Services University of the Health Sciences; Moudi Hubeishy, Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo; Rebecca Haines, Texas A&M College of Medicine

Subject: Understanding Philanthropic Efforts to Address the Rise of Medical School Tuition

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Medical school tuition has dramatically increased since 2004 - the average medical school tuition in 2004-2005 was $14,296/$32,245 (public/private) versus the average medical school tuition in 2016-2017 was $30,053/$50,599 (public/private);[1] and

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;[2-7] 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;[8] and

Whereas, Existing AMA policy pertinent to the resolution topic called for the study of strategies to limit student debt most recently in 2004 and published reports most recently in 2005;[9] and

Whereas, Levels of indebtedness have increased far more than inflation and physician compensation;[4,10,11] and

Whereas, Greater educational debt is associated with decreased career satisfaction, negative effects on personal work-life balance, and burnout;[12-14] and

Whereas, Policy efforts to improve physician workforce diversity and to mitigate shortages in the primary care workforce are inhibited by rising levels of medical student tuition and subsequent indebtedness;[12,15-18] and

Whereas, Select medical schools cite tuition-free and tuition-reduced programs as a means to generate diversity in their post-graduate specialty choice;[19] and

Whereas, Some medical schools throughout the country, including recently a top-ten private institution, have implemented tuition-free and tuition-reduced programs in order to foster inclusivity in their applicant pools;[19] therefore be it

RESOLVED, That our AMA-MSS study the financial sustainability and factors enabling the implementation of tuition-free and tuition-reduced undergraduate medical education programs; and be it further

RESOLVED, That our AMA-MSS study the efficacy of using tuition-free and tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students.

Fiscal note: Minimal, 5

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Medical School Tuition and Opposition to Tax Increases H-305.934
1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools. 2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity.

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.

Strategies to Combat Mid-year and Retroactive Tuition Increases D-305.983
Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.

Medical School Financing, Tuition, and Student Debt D-305.993
1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should

collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.
2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.
3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.
5. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
6. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.
7. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.
8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.
9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.
10. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.
11. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.
12. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.
13. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.
14. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928
1. Our AMA will make reducing medical student debt a high priority for legislative and other action and will collaborate with other organizations to study how costs to students of medical education can be reduced.

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

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 30
(I-18)

Introduced by: Region 1; Matthew Hidalgo, University of Texas Rio Grande Valley School of Medicine

Subject: Bridging the Gender Pay Gap

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, a 2018 survey of 65,000 licensed physician from 50 metropolitan areas in the U.S. reveals a deep pay gap in medicine, with female physicians earning an average of 27.7% less than their male counterparts, amounting to an adjusted average of over $105,000 a year;[i]

Whereas, this most recent research confirms trends identified in evaluations of objective, non-self reported data from the 2014 Medicare Fee-for-Service Provider Utilization and Payment Data, which shows that female physicians earn at least $19,301 less than male physicians;[ii]

Whereas, this trend is worsening, with the 2018 analysis indicating that the gender gap increased from 2016 to 2017 for more than half of the cities evaluated, with the gender pay gap ranging from as high as $134,499 in Charleston, South Carolina to $68,758 in Rochester, New York;[iii]

Whereas, the gender gap persists when adjusted for specialty and other known factors that affect financial compensation, with, for example, female urologists making $76,000 less than male urologists on average;[iv] and

Whereas, it remains deeply entrenched in academic medicine, with average yearly salaries of women at $19,878 less per year, even when controlled for specialty, institution, hours worked and faculty rank;[v] [vi] and

Whereas, this gender gap exists despite the fact that women have accounted for about half of graduates from US medical schools since 2002, and even outnumber male graduates in several states, such as Pennsylvania, Minnesota, Washington and Missouri;[vii] and

Whereas, wage disparities are not justified by discrepancies in clinical performance; in fact, female physicians consistently achieve equal if not better clinical[viii] and surgical[ix] outcomes than male clinicians; and

Whereas, research shows that unequal pay, particularly in the face of equal medical school debt, may be leading to physician dissatisfaction, burnout and even forcing female physicians to turn to other industries with more equitable compensation;[x] [xi] and

Whereas, for example, the gender gap appears to be partially driven by the fact that over 85% of private practices, which have the highest annual compensation, are owned by men, although the gender pay gaps exists in *every* practice setting, including independent contractor, employee, industry and government;[xii] and

Whereas, research finds that differences in starting salaries can lead to pay-gaps persisting over time, suggesting a lack of transparency around medical salaries and compensation structures can prevent women from negotiating equal and appropriate pay;[xiii] [xiv] and

Whereas, some fields have made concerted and successful efforts to close the pay gap, such as radiology, where 20% salary differences among academic radiologists in a sample of 24 public medical schools evened out from 2013 to 2016, largely due to increased transparency in compensation and the creation of gender-blind promotion pathways;[xv] therefore be it

RESOLVED, That our AMA-MSS support equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace; and

RESOLVED, That our AMA-MSS advocate for pay structures based on objective, gender-neutral objective criteria, with a focus on how subtle differences in the compensation of physicians of different genders may impede career advancement; and be it further

RESOLVED, That our AMA-MSS promote efforts to address gender-based disparities in physician salaries, wages and other forms of compensation, including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based pay gaps.

Fiscal Note: Significant, 11

Date Received: 09/23/2018

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RELEVANT AMA POLICY

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.
Citation: (BOT Rep. 19, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13)

Advancing Gender Equity in Medicine D-65.989:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.

2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 31
(I-18)

Introduced by: Region 1; Region 5

Subject: Advocate to End Child Marriage in the United States

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The United Nations defines child marriage as a marriage where one or both of the spouses are under 18;[1] and

Whereas, The Convention of the Rights of the Child, supported by the AMA (policy H-60.952), establishes the right of children to health, education, protection from violence, and protection from sexual exploitation and abuse, all of which are violated by child marriage;[1, 2] and

Whereas, The Convention of the Rights of the Child has been signed by almost every country including the United States;[1, 2] and

Whereas, The US Global Strategy to Empower Adolescent Girls was released in 2016 by the State Department and states that marriage before age 18 is a “human rights abuse” that produces devastating effect on a girl’s life;[3] and

Whereas, Between 2000 and 2010 more than 167,000 children across 38 states were married, mostly to men 18 or older while the remaining 12 states and the District of Columbia did not track this information;[4] and

Whereas, 87% of the minors in the United States married between 2000 and 2015 were young girls;[5] and

Whereas, In most US states the minimum marriage age is 18; however, there are many legal exceptions to this rule: 25 states allow a minor of any age to marry with parental consent and 9 states allow exceptions to their minimum age if the minor is pregnant;[4, 6] and

Whereas, Marriages that occur before the age of 15 are considered “very early marriages” and have a particularly negative impact on girls, interrupting their educations and acutely jeopardizing their health;[2, 7] and

Whereas, Child marriage in the U.S. is associated with a 23% greater risk of disease onset, including heart attack, diabetes, cancer, and stroke;[8] and

Whereas, Child marriage is associated with higher rates of sexually transmitted infections, early pregnancies, divorce, and intimate partner violence than women married at 21;[7, 9, 10] and

Whereas, Mothers around the world who are under the age of 18 have a 35% to 55% higher risk of delivering a preterm or low-birthweight infant than mothers older than 19 years;[11] and

Whereas, Child marriage in the USA has been associated with significantly increased risk of almost all psychiatric disorders; approximately 35% of women who were married as children presented with psychiatric disorders and 53% had a lifetime history of psychiatric illnesses;[7,12] and

Whereas, Delaware was the first state in the United States to ban child marriage with no exception based on the consideration that children under 18 are unable to file for divorce or seek shelter at a domestic violence shelter if needed;[13] and

Whereas, AMA policy H-60.948 and H-60.949 affirms that the rights of the child including their safety and well-being should not be infringed upon, but existing policy does not specifically address child marriage and the harms associated with it; therefore be it

RESOLVED, That our AMA advocate for ending the practice of child marriage in the United States.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

AMA Support for the United Nations Convention on The Rights of the Child H-60.952
Our AMA supports the United Nations Convention on the Rights of the Child and urges the Administration and Congress to support the Convention by ratifying it after considering any appropriate Reservations, Understandings, and Declarations.

Child Protection Legislation H-60.948
The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes.

Opposition to Parental Rights Amendments H-60.949
The AMA opposes state or federal legislative proposals (sometimes but not always known as "Parental Rights Amendments") that might give parents the right under law to harm a child or adolescent, and educate its members and the public regarding the potentially dangerous effects such initiatives represent to the public health and particularly to the health of our children.

Family and Intimate Partner Violence H-515.965
(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing

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

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

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

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

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 32
(I-18)

Introduced by:	Region 1; Region 3; Region 5; Region 6; Samuel Dubin, NYU School of Medicine; Allison Rhodes, Tufts University School of Medicine; Sean Donegan, Albert Einstein College of Medicine
Subject:	Sexual and Gender Minority Populations in Medical Research
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Of those individuals in the United States identifying with one or more sexual and gender minority (SGM) category, approximately 8 million adults identify as lesbian, gay, or bisexual, and 700,000 adults identify as transgender;[1] and

Whereas, In 2016, the National Institute of Minority Health and Health Disparities, part of the National Institutes of Health (NIH), designated sexual and gender minorities a health disparity population for research purposes;[2] and

Whereas, The NIH established in 2015 a Sexual and Gender Minority Research Office[3] that provides funding earmarked for SGM-specific medical research;[4] and

Whereas, There continues to be a paucity of research regarding health care issues affecting lesbian, gay, bisexual, and transgender (LGBT)-identified youth[5] and older adults;[6] and

Whereas, Research is further lacking on integrated care interventions that could address the health needs and care of LGBT individuals;[7] and

Whereas, Investigators failing to collect sexual preference data on study participants has been identified as a barrier to detecting health trends among SGM populations;[8] and

Whereas, Despite the relative scarcity of studies that record SGM identifiers such as sexual orientation, transgender status, and differences/disorders of sex development, research has shown significant disparities among SGM groups and between those populations and the general public vis-à-vis: 1) modifiable risk factors for cardiovascular disease such as mental distress, obesity, hypertension, and HbA1C levels;[9] 2) prevalence and predictors of obesity;[10] 3) prevalence of type 2 diabetes;[11] 4) risk of mortality from breast cancer;[12] 5) mental health and substance use disorders, including use of tobacco and electronic nicotine vapor devices;[13,14] 6) sexually transmitted illnesses such as human immunodeficiency virus and syphilis;[15] and 7) suicidal ideation and suicidality;[16] and

Whereas, The Department of Health and Human Services' Office of Disease Prevention and Health Promotion, as a part of the Healthy People 2020 initiative, set a goal of increasing the number of states that include questions identifying sexual orientation and gender identity on state level surveys and/or data systems;[17] and

Whereas, Collecting data on patients' sexual orientation and gender identity in the electronic health record is supported by the 2011 Institute of Medicine's report on LGBT health, Healthy People 2020, the Affordable Care Act, and the Joint Commission;[18] and

Whereas, Pursuant to existing AMA policy H-460.909, our AMA believes research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status; and

Whereas, Pursuant to existing AMA policy H-460.907, our AMA encourages research into specific areas affecting the health of SGM populations, including the impact of long-term administration of hormone replacement therapy in transgender patients; and

Whereas, Pursuant to existing AMA policy H-160.991, our AMA believes in 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; and

Whereas, Pursuant to existing AMA policy H-315.967, our AMA supports collection of patient data that is inclusive of sexual orientation/gender identity in medical documentation and related forms, including in electronic health records, for research purposes but is unclear in its position as to collection of this data in the context of research studies; therefore be it

RESOLVED, That our AMA amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

> Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
>
> 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 in medical documentation and in medical research studies, according to current best practices, that is inclusive of ~~sexual orientation/gender identity~~ sexual orientation, gender identity, and other sexual and gender minority traits such as differences/disorders of sex development for the purposes of research into patient and population health.

Fiscal note: Minimal, 6

Date received: 09/12/18

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RELEVANT AMA AND AMA-MSS POLICY:

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ 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 LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ 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 sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy 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; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ 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 LGBTQ people.

CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17

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.

Res. 212, I-16 Reaffirmed in lieu of: Res. 008, A-17

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients H-460.907
Our AMA encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients.

Res. 512, A-11

Comparative Effectiveness Research H-460.909
The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.

B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.

C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.

D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.

E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

CMS Rep. 5, I-08 Reaffirmed: Res. 203, I-09 Reaffirmation I-10 Reaffirmed: CMS Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 33
(I-18)

Introduced by: Jenna Guma, Amanda Rubin, Prutha Shah, and Nehi Patel, Rowan School of Osteopathic Medicine; Arjun Kumar and Brian Niedzwecki, New York Institute of Technology School of Osteopathic Medicine; Richard Saporito Rutgers New Jersey Medical School; Harshitha Dudipala, Northeast Ohio Medical University

Subject: Encouraging Stocking Epinephrine Auto-Injector Devices at Restaurants

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Food allergies are a growing public health and food safety concern affecting an estimated 15 million U.S. residents, including 1 in every 13 children1; and

Whereas, Food-related anaphylaxis is responsible for approximately 30,000 emergency room visits, 2,000 hospitalizations, and 150 deaths each year in the United States1; and

Whereas, As much as 34% of food allergic reactions occur in restaurants1; and

Whereas, EpiPens and other epinephrine auto-injectors devices are the first line of treatment for anaphylaxis and are easy to operate2,3; and

Whereas, low cost online certification classes are available to train employees in signs of anaphylaxis and using epinephrine auto-injectors4; and

Whereas, As of 2017, at least seven states are considering legislation that requires restaurants to have increased food allergy awareness and mandatory staff training,5,6,7,8,9; and

Whereas, under Occupational Safety and Health Standards, first aid kits are required to contain at minimum certain medical supplies, not including epinephrine auto-injectors10,11; and

Whereas, Although prices of epinephrine auto-injector devices have traditionally been high, their use is associated with a lower risk of hospitalization and a generic brand was just approved12,13; and

Whereas, Existing AMA-MSS policy “pursues federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA and which allergens the menu item contains.” (D-440.932); therefore be it

RESOLVED, That our AMA support the stocking of epinephrine auto-injector devices in standard first aid kits in food service establishments; and be it further

RESOLVED, That our AMA support having employees that are educated in the signs of anaphylaxis; and be it further

RESOLVED, That AMA Policy D-440.932 be amended by addition to read as follows:

Preventing Allergic Reactions in Food Service Establishments D-440.932

Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains; and (4) encourage restaurants to keep epinephrine auto-injector devices in their standard first aid kit and encourage having employees trained in the signs of anaphylaxis.

Fiscal note: Moderate, 7

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Allergic Reactions in Food Service Establishments D-440.932

1. Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 34
(I-18)

Introduced by: Samuel L. Boderman, Spencer Weintraub, and Michael Blotner, New York Medical College; Brianna J. Lally, Albert Einstein College of Medicine

Subject: Introducing Teach-Back Education into Medical School Curriculum

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Individuals with limited health literacy are less likely to control chronic medical conditions properly, which has directly led to a greater number of emergency department visits and hospitalizations[1,2]; and

Whereas, Studies have found a financial cost of approximately $10,000 for each readmission due to a variety of factors, including failure of appropriate chronic disease management[2,3,4]; and

Whereas, Patient education, including proper medication counseling, has led to a significant reduction in 30-day readmission rates among those with diabetes, recent surgical procedures, and emergency department visits[5-10]; and

Whereas, Successful patient education programs reduce costs on the healthcare system in terms of readmission rates and overall management of chronic disease[3,4]; and

Whereas, Asking patients to summarize care plans to providers using their own words, “teach-back”, can elucidate lapses in communication between the clinician and the patient[11], particularly among individuals with less formal education[9]; and

Whereas, In a 46-state study, both healthcare providers and hospital administrators stated that teach-back/discharge education is the most important determinant for pediatric patient success after discharge[12]; and

Whereas, Training healthcare providers how to educate patients prior to discharge and providing a standard protocol for hospital education for staff has shown a significant reduction in hospital readmissions[13] ; and

Whereas, Studies have demonstrated that a significant majority of medical students and residents report feeling a lack of competency in their ability to educate effectively and counsel patients with limited health literacy[1,14]; and

Whereas, Medical students and residents report discrepancies in exposure to limited health literacy-related curricula, with over 50% denying prior experience with health literacy education[1,14]; and

Whereas, Existing AMA policy "recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment" (H-160.931) and "encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills" (H-160.931); and

Whereas, 2018 Liaison Committee on Medical Education (LCME) guidelines state that medical students must be educated how to provide preventive care and health promotion to patients,[15] yet lacks methods for standardizing this curriculum across medical schools[14,16]; therefore be it

RESOLVED, That our AMA-MSS Council on Medical Education (CME) study the efficacy of teach-back in regard to patient education and hospital readmission frequencies.

Fiscal Note: Minimal, 4

Date received: 09/22/18

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RELEVANT AMA AND AMA-MSS POLICY:

Health Literacy H-160.931

Our AMA:

(1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;

(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;

(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;

(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;

(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;

(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
(7) encourages the allocation of federal and private funds for research on health literacy;
(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

Evidence-Based Principles of Discharge and Discharge Criteria H-160.942
1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
(2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.
(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.
(4) The AMA promotes the local development, adaption and implementation of discharge criteria.
(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.
(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.
(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:
(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.
(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of

dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.
(c) The discharge process includes,,but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

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

Hospital Discharge Communications H-160.192
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:

a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

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.

Hospital Discharge Communications H-160.902
1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:

a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 35
(I-18)

Introduced by: Region 3, Region 5, Region 7, Student National Medical Association; Lakshmi Karamsetty, University of Colorado School of Medicine; Drayton Harvey, University of Southern California School of Medicine

Subject: Increasing Access to Trauma-Informed Services within Schools

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Studies have shown approximately two out of every three school-age children are likely to have experienced at least one traumatic event by age 17. Children and adolescents in the United States experience high rates of trauma and adversity from a wide variety of sources, which, include but are not limited to physical and emotional abuse, neglect, bullying, mass shootings, and family instability[1-3] and

Whereas, Traumatic events have an impact on a child's ability to learn and succeed in the learning environment; [4] and

Whereas, The Adverse Childhood Events (ACEs) study demonstrates that adverse childhood experiences are strong predictors of negative adulthood outcomes and increased health related problems such as mental illness, substance abuse, heart disease, and early death, depression suicide attempts, and smoking;[5] and

Whereas, the American Academy of Pediatrics (AAP) recognizes the relationship between Toxic Stress and ACEs, calls for a need for sound investments in interventions that can lessen the burden of adversity, and believes that addressing these adversities would generate even larger returns to all of society. Pediatricians who are leaders in forming trauma-informed medical practices are advocating for community-based interventions in preschools and schools [6, 7] and

Whereas, National Child Traumatic Stress Network defines a trauma informed service as one in which all parties involved recognize the impact of traumatic stress, support the recovery and resiliency of children and families affected by trauma, and require that all school personnel have basic understanding of trauma and how it affects student learning and behavior. SAMHSA defines a trauma informed service to follow a trauma informed approach, which includes six principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment voice and choice; cultural, historical and gender issues and; [8, 9]

Whereas, while existing school-based programs address social and emotional developmental problems, these programs do not sufficiently include mental health services that trauma-informed service can provide. School-based mental health services are more effective when they are evidence-based, trauma-informed, and culturally responsive, especially in engaging underrepresented minority (URM) and in addressing mental health issues unique to URM students; [10]

Whereas, current evidence-based school-based trauma informed services that have been shown to be effective in addressing trauma, are the following: TF-CBT (Trauma Focused-Cognitive Based Therapy), CBITS (Cognitive Behavioral Intervention for Trauma in Schools), and MHIP (Mental Health for Immigrants Program); [11]and

Whereas, School-based trauma informed services can decrease post-traumatic stress disorder (PTSD) symptoms among children and adolescents who were exposed to a variety of trauma, including most recently for Mexican and Central American unaccompanied refugee minors who benefited from TF-CBT in an urban public high school;[12]and

Whereas, A study looking at students from three New Orleans schools affected by Hurricane Katrina showed a statistically significant decrease in PTSD scores after using a CBTIS approach;[13] and

Whereas, A study showed that, using a CBITS approach at two middle schools in East Los Angeles, students who received early intervention after positively screening for incidence of trauma earned better grades in school as compared to the students that received delayed intervention after positive screening;[14] and

Whereas, The San Francisco Unified School District's implementation of the Healthy Environments and Response to Trauma in Schools (HEARTS) program at an elementary school saw a decrease in trauma-related symptoms in students, as well as a significant drop in disciplinary office referrals and out-of-school suspensions; [15]and

Whereas, A 2017 federal mandate titled *Every Student Succeeds Act* supports school-based trauma-informed services that "provide comprehensive school-based mental health services and supports and staff development for school and community personnel working in the school";[15] and

Whereas, Despite this federal mandate, trauma-informed services within schools have only been implemented at the district and state level in seventeen states; [15,16]and

Whereas, the Institute of Medicine and National Research Council summary on prevention-based logic for behavior and schools within integrated model for the prevention and intervention of mental, emotional and behavioral disorders recommended: "States and communities should develop networked systems to apply resources to the promotion of mental health and prevention of MEB disorders among their young people. These systems should involve individuals, families, schools, justice systems, health care systems, and relevant community-based programs. Such approaches should build on available evidence-based programs and involve local evaluators to assess the implementation process of individual programs or policies and to measure community-wide outcomes." [17]

Whereas, The American Medical Association has existing policies (H-60.919, H-60.943,H-60.991) which recognize and support trauma-informed services, but there is no policy for school-based services; therefore be it

RESOLVED, That Our AMA encourage physicians, residents, and medical students to become educated in the existence of school-based trauma informed services such as MHIP, CBITS, TF-CBT; and be it further

RESOLVED That Our AMA work with stakeholders to encourage current and future implementation of trauma-informed school based services.

Fiscal Note: Significant, 10

Date Received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY

Relevant AMA Policy:

National Child Traumatic Stress Network H-60.929
Our AMA: (1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; (2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network. Res. 419, A-11

Juvenile Justice System Reform H-60.919

Our AMA Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance' policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system. (2)encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.(3)encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age. (4)supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.(5) supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.(6) encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.(7) encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community. (8) encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts CSAPH Rep. 08, A-16 Reaffirmed: Res. 917, I-16

Bullying Behaviors Among Children and Adolescents H-60.943

Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim(2)advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents.(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behavior(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion. CSA Rep. 1, A-02 Reaffirmed: CSAPH Rep. 1, A-12

Legal Protection and Social Services for Commercially Sexually Exploited Youth-60.023MSS

That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth.

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 36
(I-18)

Introduced by: Region 5; Drayton Harvey, Keck School of Medicine of USC; Ellena Popova, University of Pennsylvania Perelman School of Medicine; Shiri Nawrocki, Rutgers-Robert Wood Johnson Medical School

Subject: End Punitive Measures for Pregnant Women Who Use Drugs

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, A 2012 national survey in the USA found that 5.9% of pregnant women used illicit drugs, 8.5% consumed alcohol and 15.9% smoked cigarettes;[1] and

Whereas, In 2014, the prevalence of opioid use disorder in pregnant women was 6.5 per 1,000 births and the prevalence of neonatal abstinence syndrome (NAS) has increased significantly in the United States in the past decade 6.0 per 1,000 births;[2,3] and

Whereas, Substance misuse during pregnancy is considered to be child abuse in 23 states—going against the AMA's stance on the issue (H420.950)—and cases have been documented where women have been arrested despite voluntarily participating in substance use treatment programs;[4,5] and

Whereas, In Tennessee, Alabama, North Carolina, and South Carolina drug use by pregnant mothers is a prosecutable offense and women have been tried for substance use during pregnancy in forty five states since 1973;[6,7,8] and

Whereas, The most stringent laws around maternal substance use are in Alabama where mothers can be administered a drug test without consent at many hospitals and the punishment for a single positive drug test range from up to ten years in prison if the baby shows no signs of harm and up to 20 years if the baby shows signs of exposure with the added risk of losing custody of all her children;[9,10] and

Whereas, AMA policy H-420.969 currently states that "criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate"; and

Whereas, The American Academy of Pediatrics affirms that "punitive measures taken toward pregnant women such as criminal prosecution and incarceration, have no proven benefits for infant health", a position that was reaffirmed in 2017;[11,12] and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) recommends that screening for substance abuse should be part of comprehensive obstetric care, should be done at the first prenatal visit at the partnership with the pregnant woman, and should be universally performed to minimize stereotyping and stigma;[13] and

Whereas, African American women have been shown to be disproportionately targeted and tested for substance use, with African American women and their children found to be tested 1.5x more often than non-black women and children, indicating that policies aimed at maternal substance use are being applied in a racially biased manner;[4,14] and

Whereas, The Supreme Court has found that involuntary drug testing of pregnant women is a violation of the Fourth Amendment;[15,16,17,18] and

Whereas, The Committee Opinion from the American College of Obstetricians and Gynecologists encourages physicians to "retract legislation that punishes women for substance abuse during pregnancy";[19] and

Whereas, Our AMA opposes the criminalization of maternal drug addiction, acknowledges that punishment is not an effective way to cure drug dependency or prevent future abuse, and recommends treatment and education as the most effective method for reducing maternal and fetal harm (H-420.970);[20] and

Whereas, Punitive legislation and physician bias are major barriers to accessing substance abuse treatment and prenatal care for pregnant women, resulting in negative maternal and fetal outcomes;[21] and

Whereas, Children who are removed from homes because of parental substance abuse are more likely to remain in foster care for longer, are moved between more placements, and are less likely to be reunited with their families, resulting in significant trauma;[22,23] and

Whereas, Over 32 years (1973 and 2005), there were at least 413 arrests on women for this conduct while pregnant compared to 380 arrests over a recent 9 year period between 2005 and 2014 and it is estimated that over 80% of these arrests have mentioned use of illegal substances;[4,24] and

Whereas, Although there are no current statistics on the scope of the problem today, anecdotal evidence of infant separation for positive drug tests has created enough fear in pregnant women that some avoid pre-natal care and even avoid visiting the hospital for childbirth;[25,26] and

Whereas, A child can be removed from its mother after birth for reasons other than an official accusation or conviction of child abuse, this may occur when the health of the infant or standard protocol requires the infants entry to the Neonatal Intensive Care (NICU);[27,28,29] and

Whereas, Many infants born to mothers who test positive for illicit substances are taken to the NICU immediately after birth;[29,30,31] and

Whereas, Maternal-Neonate Separation (MNS) is associated with increased neonatal physiological stress response and decreased sleep duration when compared with skin-to-skin contact;[32,33]and

Whereas, Allowing an infant with Neonatal Abstinence Syndrome (NAS) to remain with the mother (rooming-in) is associated with a shorter length of stay and fewer days of infant opioid therapy;[34] therefore be it

RESOLVED, That our AMA oppose the removal of a child from its mother during the hospital stay solely due to evidence from a single positive drug test; further be it

RESOLVED, That our AMA amend policy H-420.950 (Substance Use Disorders During Pregnancy) by insertion as follows:

> Substance Use Disorders During Pregnancy H-420.950
> Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; and (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose any practice that results in pregnant women receiving drug screens without appropriate informed consent; (4) oppose the removal of infant from their mothers solely based on a single positive prenatal drug screen

Fiscal note: Moderate, 8

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Substance Use Disorders During Pregnancy H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; and (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy.

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:
(1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.

(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation.

H-420.970 Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy:
(1) to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity;
(2) to forewarn the U.S. government and the public at large that there are extremely serious implications of drug addiction during pregnancy and there is a pressing need for adequate maternal drug treatment and family supportive child protective services;
(3) to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment; and
(4) to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.

H-420.962 Perinatal Addiction - Issues in Care and Prevention:
(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability;
(2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible;
(3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children;
(4) reaffirms the following statement: Pregnant patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and
(5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

H-95.976 Drug Abuse in the United States - the Next Generation:
Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;

(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 37
(I-18)

Introduced by: Region 5

Subject: Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The 8-year graduation rate of allopathic medical students in the United States who were not in dual-degree programs that matriculated in 2000-2001 and 2004-2005 was 97.5%;[1] and

Whereas, For United States allopathic medical students who were not in dual-degree programs that matriculated in 2000-2001 and 2004-2005 and took leaves of absence for reasons other than pursuing a dual degree or for research, the 8-year graduation rate was 68.8%;[1] and

Whereas, A study of medical students in the state of Michigan found that underrepresented minority students had twice the rate of attrition of non-underrepresented students, but did not identify causes for the discrepancy;[2] and,

Whereas, studies in England and Ireland have identified timepoints in their curriculum at which British and Irish medical students are most likely to withdraw;[3,4] and

Whereas, PubMed, JSTOR, Google Scholar, and Academic Search Complete searches on September 23, 2018 failed to identify the points in time during medical training that students at United States medical schools were most likely to take leaves of absence nor their reasons for doing so;[5-8] and

Whereas, Standard 11 of the Liaison Committee on Medical Education defines the function of a medical school to provide “effective academic support and career advising to all medical students to assist them in achieving their career goals”,[9] and

Whereas, Current AMA policy states that, “Adequate and timely career counseling should be available at all medical schools;”[10] and

Whereas, Knowing the points in time at and reasons for which medical students in the United States are most likely to take leaves of absence or withdraw may assist academic institutions in planning curricular or advising interventions; therefore be it

RESOLVED, That our AMA support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

Fiscal Note: Minimum, 6

Date Received: 09/23/18

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6. Jstor search criteria included the following search criteria: ((Medical Student) AND (Attrition)) as well as ((Medical Student) AND (Leave of Absence)) (date: 2010-present)

7. Google Scholar search criteria included the following search criteria: (exact words: Medical Student) AND (exact phrase: Leave of Absence) (date: 2012-present)

8. Academic Search Complete criteria included the following search criteria: ((Medical Student) AND (Leave of Absence)) (date: 2010-present)

9. Liaison Committee on Medical Education. Functions and Structure of a Medical School. March 2017. http://lcme.org/publications/ Accessed September 23, 2018.

10. AMA Policy H-295.895 Progress in Medical Education: Structuring the Fourth Year of Medical School

RELEVANT AMA AND AMA-MSS POLICY

For-Profit Medical Schools or Colleges D-305.954
Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.

11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.

16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable

Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will 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.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA will investigate the status of implementation of AMA Policies D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and report back to the House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Progress in Medical Education: Structuring the Fourth Year of Medical School H-295.895

It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences.
(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training.
(3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge.
(4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives.
(5) Adequate and timely **career** counseling should be available at all medical schools.
(6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.
(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills.

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.

(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) 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.

(31) 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.

(32) 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.

(33) 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.

(34) 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.

(35) 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.

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970
Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner.

Medical Student and Housestaff Alcoholism 30.001MSS
AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students. (AMA Amended Res 83, I-82 Adopted [H-30.961]) (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)

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, I02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12)

Preserving Our Investment in the Face of Medical School Class Size Reductions 295.075MSS
AMAMSS (1) supports protections for medical students and accordant AMA action to ensure proper placement of displaced students in the event of medical school closures or class size reductions that do not allow for natural attrition of those currently enrolled; and (2) supports encouraging the Liaison Committee on Medical Education to develop guidelines for institutions to follow in the event of medical school closure or immediate class size reductions that provide for adequate notification and placement assistance for the affected medical students. (MSS Sub

Res 21, A-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I16)

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. (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)

Addressing Student Debt in Medical School Attrition Due to Mental Illness 305.081MSS
That our AMA-MSS support the study of mechanisms for dismissing federal loan obligations for students who withdraw from medical school due to a diagnosed mental and/or physical illness (MSS Res 13, A-18)

Addressing the Increasing Number of Unmatched Medical Students 310.050MSS 310.051MSS
AMA-MSS will ask that the AMA (1) study, in collaboration with the Association of American Medical Colleges (AAMC) and the American Osteopathic Association (AOA), the common reasons for failures to match; and (2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program (NRMP) who fail to match. (MSS Res 3, I-14)

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution: 38
(I-18)

Introduced by: Region 2

Subject: Evaluating Medical Service Trips (MSTs) Sponsored by Accredited U.S. Medical Institutions

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Medical service trips (MSTs) are defined as trips in which volunteer medical students travel to low and middle-income countries (LMICs) on programs sponsored by their medical institution to provide health care over periods ranging from 1 day to 8 weeks;[1] and

Whereas, The financial investment for short-term MSTs is significant with conservative estimates for annual expenditures from teams departing from the United States totaling $250 million;[2] and

Whereas, While some organizations provide a breakdown of expenditures, this is not the case for the majority of MSTs;[3] and

Whereas, With the equivalent expenditures of a visiting non-surgical team, one physician pointedly argued that “it would be possible to recruit, educate and retain a local doctor, nurse and support staff to man the same clinic for a year”;[4] and

Whereas, MSTs have not faced the same rigorous scrutiny applied to clinical research performed in LMICs;[5] and

Whereas, Nearly 95% of literature on MSTs published from 1993 to 2013 lacked significant data collection on interventions or outcome;[6,7] and

Whereas, Published studies on cost-effectiveness of short-term MSTs solely discuss surgical interventions, while no studies identified address cost-effectiveness of non-surgical interventions;[8,9] and

Whereas, No existing data addresses long-term outcomes of interventions performed by strictly medical teams, which are more commonly staffed by student volunteers;[10] and

Whereas, Monetary donations to evidence-based organizations with established grassroots partnerships in LMICs can have measurable impacts on outcomes including, but not limited to, prevention of premature death and life-years gained;[11] and

Whereas, International health volunteer work presents significant ethical challenges, including being characterized as self-serving and ineffective, raising unmet expectations, imposing burdens on and diverting business from local health facilities, and failing to follow current standards of health care delivery or public health programs;[12,13,14] and

Whereas, AMA policy H-250.993 states that students participating in global health programs are held to the same ethical standards as **s**tudents participating in domestic service-learning opportunities and ensures safe educational experiences for students, but does not address local long-term patient outcomes; and

Whereas, The seminal systematic review published about MSTs recommended that, at a minimum, MSTs should collect data regarding patient demographics, socioeconomic status, the availability of regular care in the community, and the cost of delivering the care provided by the MST;[15] and

Whereas, The National Academies of Science, Engineering, and Medicine recently published a report on global quality in health care that included a recommendation that “ongoing improvement of the quality of care in all dimensions should be the daily work and constant responsibility of healthcare leaders” and that global health partners should activate public demand for high-quality care through “measurement and transparency”;[16] therefore be it

RESOLVED, that the AMA-MSS ask the AMA to work with the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and other relevant organizations to study the number of students participating in medical service trips sponsored by accredited US medical schools, the structure of such programs including interventions performed, associated costs, and outcomes that result from these interventions; and be it further

RESOLVED, that the AMA-MSS ask the AMA to work with the aforementioned organizations to share best practices for medical service trips and to evaluate whether sending trainees to low and middle-income countries is a sustainable and evidence-based use of resources with regards to both medical student education and local patient outcomes and; and be it further

RESOLVED, that the AMA-MSS ask that the AMA amend policy H-250.993 (Overseas Medical Education Developed by US Medical Associations) by insertion as follows:

> H-250.993 Overseas Medical Education Developed by US Medical Associations
> The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in

various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measurable 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; and (7) support that local populations served derive tangible and sustainable benefit from international medical interventions provided by medical students.

Fiscal Note: Significant, 12

Date Received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Overseas Medical Education Developed by US Medical Associations H-250.993
The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measurable 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.

Medical School International Service Learning Opportunities 295.156MSS
AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical school international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and (2) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities. (MSS Res 13, I-10) (AMA Res 307 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

Voluntary Reporting of Complications from Medical Tourism 250.025MSS
AMA-MSS will ask that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad. (MSS Res 20, I-15) (AMA Res 703, A-16 Adopted as Amended)

Global Health Education 295.155MSS
AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning opportunities in their medical education curricula. (MSS Res 9, I-10) (AMA Res 310 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief 250.023MSS
AMA-MSS (1) supports the efforts of the Global Health Service Partnership to strengthen African healthcare 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)

Emphasizing Training in the Treatment of Refugees 250.027MSS
AMA-MSS supports medical student collaboration with appropriate entities for training in the provision of refugee medical care. (MSS Res 08, I-16)

Promotion of Rapid HIV Test 20.014MSS
AMA-MSS will ask the AMA to work with any and all local and state medical societies, and other interested U.S. and international organizations to increase access to and utilization of FDA approved rapid HIV testing by personnel appropriately trained in test administration and results counseling. (MSS Res 30, I-04) (AMA Amended Res 511, A-05 Adopted [D-20.993]) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Global Health Education 295.155MSS
AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning opportunities in their medical education curricula. (MSS Res 9, I-10) (AMA Res 310 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

Establishing an AMA International Health Consortium 530.020MSS
AMA-MSS will ask the AMA to establish an "international health consortium" of physicians, residents, and medical students interested in promoting international health issues. (MSS Res 26, A-04) (AMA Res 608, A05 Withdrawn) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I16)

Medical Care in Countries in Turmoil 250.001MSS
AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical equipment to civilians threatened by natural disaster or military conflict within their country; (2) express concern about the disappearance of physicians, medical students, and health care

professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries. (AMA Amended Res 133, A-83 Adopted [H-65.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials 460.017MSS

AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; (2) sign the petition titled “All Trials Registered; All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (3) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and (4) encourage the expansion of clinical trial registrants to clinicaltrials.gov. (MSS Res 23, A-15) (First, third, and fourth Resolves of Res 907, I-15 Adopted as Amended, H-460.912 and D-460.970 Reaffirmed)

Global HIV/AIDS Prevention 250.019MSS

AMA-MSS will ask the AMA to (1) support 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; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (MSS Late Res 3, A08) (AMA Res 438, A-08 Withdrawn) (Reaffirmed: GC Rep B, I-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 39
(I-18)

Introduced by: Caroline Plott, Alina Spiegel, Ellie Burton, and Neha Anand, Johns Hopkins University School of Medicine; Sadhvi Batra, University of Alabama School of Medicine; Harshitha Dudipala, Northeast Ohio Medical University

Subject: Provision of Longitudinal Medical Care to Babies, Mothers, and Caregivers Impacted by Substance Use and Exposure

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Neonatal Abstinence Syndrome (NAS) is a serious health consequence of exposure to opioids in utero and results in symptoms of withdrawal after birth including seizures, seizure-like jerking movements, and general infant distress;[1] and

Whereas, Neonatal Abstinence Syndrome is associated with maternal use of opioids, both prescribed and non-prescribed, during pregnancy, and maternal use of opioids during pregnancy has been increasing in the United States; [1] and

Whereas, studies have reported up to 39.4% of Medicaid insured women of childbearing age filled a prescription for an opioid in 2009-2012, and that 21.6% of pregnant women with Medicaid insurance filled an opioid prescription during their pregnancy in 2000-2007; [2] [3] and

Whereas, the prevalence of Neonatal Abstinence Syndrome in 2012 was 5.8 per 1000 babies born in US hospitals, approximately five times the rate that was recorded in 2000; [4] and

Whereas, the cost of hospitalization and care of a baby affected by Neonatal Abstinence Syndrome is approximately $16,893, and approximately $316 million was spent on Neonatal Abstinence Syndrome hospitalizations in the US in 2012;[5] and

Whereas, in addition to opioid exposure, maternal use of other substances such as alcohol, cocaine, nicotine, and others can lead to a myriad of health consequences for the infant;[6] and

Whereas, there are limited existing post-discharge guidelines for further care of infants or patient education protocols for mothers or other care providers exposed to opioids and other substances;[1] [7] and

Whereas, a 2017 committee opinion from the American College of Obstetrics and Gynecologists states that “women with substance use disorder should continue their opioid agonist pharmacotherapy postpartum” and should receive postpartum access to psychosocial support services, substance use disorder treatment, and overdose training, however no formal standard of care exists to provide these services; [8] and

Whereas untreated caregivers that are affected by substance addiction may experience increased difficulty building healthy caregiver-child attachment and responding to their baby's cues, which could negatively affect the quality of care that they can provide to their child;[9] [10] and

Whereas in 2017, 18 states had policies that allowed for prosecution of maternal substance use during pregnancy as child abuse, a charge which can result in maternal and child separation; [11] and

Whereas, separation of mother and child leads to greater incidence of anxiety and depression for both mother and child;[12] and

Whereas, a study of effective ways to provide care for opioid affected mothers and their babies stated that "developing pre- and perinatal treatment for substance-abusing women is demanding work, and collaboration among specialists from several disciplines (e.g., adult psychiatry, addiction psychiatry, obstetrics, pediatrics, and infant psychiatry) is critical"; [9] and

Whereas, existing AMA policy H-420.962 states that "support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible," and that "pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation"; and

Whereas, Dr. James Madara, the executive vice president of the AMA expressed support for strategies that approach caring for substance use-impacted mothers and infants with an "emphasis on services for families: the goal should be healthy families, including parents and infants";[13] and

Whereas, a review of multiple studies on the efficacy of programs with combined substance use treatment and services for the child found that children of mothers in such programs often had superior growth and behavioral outcomes compared to controls;[14] and

Whereas, comprehensive programs such as the Center for Addiction and Pregnancy (CAP) at Johns Hopkins as well as the Horizons program at University of North Carolina provide co-located tandem healthcare services to both mothers and babies affected by opioid exposure to provide better coordinated, timely, accessible care, however these programs are not widely available[15] [16] [17]; and

Whereas, the Joint Commission periodically evaluates healthcare institutions in order to ensure that the institution adheres to guidelines for safety and high quality care;[18] and

Whereas, multiple studies have shown Joint Commission accreditation to be associated with higher quality care;[19] [20] and

Whereas, existing AMA policy H-220.939 urges "the improvement of the quality and consistency of The Joint Commission accreditation process, surveyors, and survey reports"; and

Whereas, The Joint Commission offers a Behavioral Health Home accreditation program for integrated, comprehensive care of individuals affected by substance use disorders, however, no

program exists to support programs that provide tandem comprehensive care for substance use affected newborns and their caregivers;[18] therefore be it

RESOLVED, That our AMA work with experts in the field such as the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop recommendations for post-delivery discharge plans that include care and substance use treatment for the affected newborn and caregivers; and be it further

RESOLVED, That our AMA request that Center for Medicare and Medicaid Services and the Joint Commission adopt a set of standards necessitating the inclusion of substance-use treatment plan in the hospital discharge plan when medically appropriate as part of standard best practice; and be it further

RESOLVED, That our AMA ask the Joint Commission to ensure that substance-use treatment plans are included in the discharge plan when medically appropriate as part of their regular review of accredited institutions; and be it further

RESOLVED, That our AMA support the establishment of programs that provide ongoing medical treatment, education, and social support for recovering or current substance using caregivers and their substance exposed babies with an emphasis on programs that use the longitudinal tandem primary care model in order to improve health outcomes

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17

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 health care 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.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

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.

3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from **opioid addiction** and their friends/families that address how a return to **opioid** use after a period of abstinence can, due to reduced **opioid** tolerance, result in overdose and death.
Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18

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.
Res. 524, A-1; Reaffirmation A-15

Opioid Abuse in Breastfeeding Mothers 100.017MSS
AMA-MSS (1) will ask that our AMA Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines; and

(2) will ask that our AMA amend by addition existing AMA policy H420.962 Perinatal Addiction – Issues in Care and Prevention to read as follows:

Our AMA:
(1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability;

(2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and

making broadly available specialized treatment programs for drug addicted pregnant and breastfeeding women wherever possible;

(3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children;

(4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and

(5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
MSS Res 07, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 40
(I-18)

Introduced by: Lauren Benning, Campbell University School of Osteopathic Medicine; Rouzbeh Kotaki, The University of Texas Rio Grande Valley School of Medicine

Subject: Eliminating Recommendations to Restrict Dietary Cholesterol and Fat

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, the current government-sponsored guidelines for American no longer recommend restricting dietary cholesterol or total grams of fat in one's diet[1], and

Whereas, nutrient density refers to the nutrient to energy content ratio of foods and/or diets[2], and

Whereas, studies have provided nutrient profile models showing higher nutrient density to energy content is an accurate marker of healthy diets[3,4], and

Whereas, there are foods with high nutrient content and low energy content (i.e. dairy and eggs) that are recommended to be restricted in diets due to some of their macronutrient components (i.e. saturated fats), but are usually substituted for nutrient-poor and high energy content foods[5,6], and

Whereas, consumption of eggs has been shown to improve nutritional status and lower inflammation[7,8], and

Whereas, consumption of full fat dairy products been linked to a lower risk of metabolic syndrome[9], type 2 diabetes[10,11], and central obesity[12], as well as inversely associated with weight gain[13], therefore be it

RESOLVED, That our AMA amend AMA Policy H-150.944, "Combating Obesity and Health Disparities," by deletion to read as follows:

> 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,~~ healthful foods and beverages.

Fiscal note: Minimal, 6

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises. 2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages. 3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information.

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.

Taxes on Beverages with Added Sweeteners H-150.933

1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.

2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately affected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.

3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.

4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.

Quality of School Lunch Program H-150.962

1. Our 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. 2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 41
(I-18)

Introduced by: Harrison Quaal, Nora Akcasu, Zainab Almusawi, Fiona Clowney, Hannah Kopinsky, Kyal Lalk, Elizabeth Martin, Tabitha Moses, Jaya Parulekar, Samantha Rea, Brianna Sohl, Eric Walton and Jacob Wilson, Wayne State University School of Medicine; Omar Salman, Virginia Tech Carilion School of Medicine; Samuel Dubin, New York University School of Medicine

Subject: Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Human immunodeficiency virus (HIV) is a disease of significant public health importance; therefore, state mandates require physician reporting of new cases to the health department and/or Centers for Disease Control (CDC);[1,2] and,

Whereas, For all mandated reportable diseases other than HIV, the onus for reporting and disclosure falls on the physician, not the patient; [2] and

Whereas, Thirty-two states and two U.S. territories have punitive laws criminalizing failure to disclose HIV status to sexual partners if HIV-positive;[3] and

Whereas, Many of these laws were passed before the widespread availability of antiretroviral therapy (ART); [3] and

Whereas, ART results in viral suppression, which is defined as a viral load of <200 copies/mL of blood, virtually eliminating the risk of sexual HIV transmission;[4] and

Whereas, As of 2015, over 1 million adults and adolescents in the United States were living with HIV and 49% of them had achieved viral suppression; [5] and

Whereas, Three prospective studies involving both heterosexual and same-sex male couples of different HIV status showed no cases of sexual transmission of HIV from a person living with HIV (PLHIV) with an undetectable viral load suppressed by ART;[6,7,8] and

Whereas, As a result of ART, the CDC described the estimated possibility of HIV transmission from an HIV˜positive person with an undetectable viral load as “effectively no risk” based on current scientific literature;[9] and

Whereas, Data from International Epidemiology Databases to Evaluate AIDS demonstrated that of 26,000 adults on antiretroviral therapy (ART), 90% who remained in care were virally suppressed; [10] and

Whereas, Many state laws criminalize both high risk behaviors and low/negligible risk behaviors, such as spitting, biting, or having sex with someone with an undetectable viral load; in two states--MIchigan and Tennessee--one-third of HIV related arrests were associated with low risk behaviors;[11,] and

Whereas, HIV non-disclosure laws have not been shown to reduce risky sexual behavior and have led to disproportionate convictions of PLHIV that belong to minority groups; [11, 14] and

Whereas, Studies suggest HIV disclosure laws increase stigma towards PLHIV, reduce the likelihood of disclosure to sexual or needle-sharing partners, and reduce frequency of HIV testing since knowledge of status is required for legal liability;[11] and

Whereas, A consensus statement from the International AIDS Society suggested HIV criminal laws that do not reflect current understanding of HIV lead to misrepresentation of HIV transmission risk in the media that perpetuates stigma against PLHIV;[11,15] and

Whereas, A study with HIV-negative men who have sex with men (MSM) showed 7% were less likely to be tested because of disclosure laws, leading to an estimated 18.5% increase in HIV transmission, concluding HIV disclosure laws may be causing major public health complications;[16] and

Whereas, The REPEAL (Repeal Existing Policies that Encourage and Allow Legal) HIV Discrimination Act was introduced in the House of Representatives in March 2017 and in the Senate in December 2017 to provide states with guidance on best practices for revising discriminatory HIV laws and is supported by AIDS United, the HIV Justice Network, the AIDS Institute, the Drug Policy Alliance, the American Psychological Association, and the Ryan White Medical Providers Coalition;[17,18] and

Whereas, Considering laws criminalizing non-disclosure of HIV have little impact on the sexual behaviors of PLHIV and create negative public health consequences, Ontario, Canada (2017) and North Carolina (2018) removed punitive policies for HIV non-disclosure in PLHIV who are adherent to the treatment plan of an attending physician and are known to be virally suppressed for 6 months prior to sexual exposure; [11,19, 20,21] and

Whereas, In 2017, based on current scientific evidence and contemporary understanding of HIV transmission, California reduced the act of HIV non-disclosure from classification as a felony to a misdemeanor, making it equivalent with current California law against intentionally exposing another person to contagious, infectious, or communicable disease; [8,22] and

Whereas, AMA policy H-20.914 emphasizes the importance of addressing discrimination based on HIV status, including stigma arising from criminalization, and also "supports consistency of federal and/or state laws with current medical and scientific knowledge"; and

Whereas, Current reckless endangerment and battery laws would still maintain punishments for knowingly transmitting HIV even after removal of punitive laws criminalizing HIV non-disclosure; [3] therefore be it

RESOLVED, That our AMA advocate to remove legislation criminalizing non-disclosure of Human Immunodeficiency Virus (HIV) status of people living with HIV who are medically virally suppressed.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Patient Disclosure of HIV Seropositivity H-20.919
Our AMA encourages patients who are HIV seropositive to make their condition known to their physicians and other appropriate health care providers.

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 healthcare 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 provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. 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.

HIV/AIDS Reporting, Confidentiality, and Notification H-20.915
(1) Reporting
Our AMA strongly recommends that all states, territories, and the District of Columbia adopt a requirement for the confidential reportability of HIV seropositivity of all patients to appropriate public health authorities for the purpose of contact tracing and partner notification. Strict confidentiality must be maintained by each local and state public health authority.

(2) Confidentiality
a) Our AMA supports uniform protection, at all levels of government, of the identity of those with HIV infection or disease, consistent with public health requirements;
b) Patients should receive general information on the limits of confidentiality of medical records at the initial medical visit. Specific information on the limits of confidentiality should be provided before the patient receives HIV-related services or when the patient is counseled about HIV testing;
c) Physicians should be able, without fear of legal sanction, to confidentially discuss a patient's HIV serostatus only with those other health care providers who need this information to properly plan and provide quality medical care to the patient; and
d) Our AMA will continue to address, through the Council on Ethical and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV antibody-positive patients who refuse to inform their sexual partners or modify their behavior.

(3) Contact Tracing and Partner Notification
Our AMA: a) Strongly recommends that states adopt a system for contact tracing and partner notification in each community that, while protecting to the greatest extent possible the confidentiality of patient information, provides clear guidelines for public health authorities who need to trace the unsuspecting sexual or needle-sharing partners of HIV-infected persons; b) Requests that states make provisions in any contact-tracing and notification program for adequate safeguards to protect the confidentiality of HIV-seropositive persons and their contacts, for counseling of the parties involved, and for the provision of information on counseling, testing, and treatment resources for partners who might be infected; c) In collaboration with state medical societies, supports legislation on the physician's right to exercise ethical and clinical judgment regarding whether or not to warn unsuspecting and endangered sexual or needle-sharing partners of HIV-infected patients; and d) Promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom he/she might have infected. If such persuasion fails, the physician should pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly.

Discrimination and Criminalization Based on HIV Seropositivity H-20.914
Our AMA: (1) Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV

infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; (5) Supports consistency of federal and/or state laws with current medical and scientific knowledge including avoidance of any imposition of punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959
Our AMA: (1) Opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations; (2) Endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship: (a) Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient; (b) All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first; (c) The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties; (d) Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

State Tracking of HIV/AIDS and Other Serious Infectious Diseases H-440.886
1. Our AMA encourages specific statutes be drafted that, while protecting to the greatest extent possible the confidentiality of patient information: (a) provide a method for warning unsuspecting sexual partners, needle-sharing partners, or other close contacts; (b) protect physicians from liability for failure to warn the unsuspecting third party; but (c) establish clear standards for when a physician should inform the public health authorities.

2. Our AMA will assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible bloodborne disease.

Relevant AMA-MSS Policy

AMA MSS 20.019 Modernization of HIV Specific Criminal Laws

AMA-MSS will ask the AMA to amend policy H20.914 via insertion and deletion as follows:
H-20.914 Discrimination and Criminalization Based on HIV Seropositivity
Our AMA: Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 42
(I-18)

Introduced by: Mallika Tatikola, Amrit Panjabi, Daphney Noel, Kaavya Mahajan, Jessica Ohiri, Nisha Naik, Sneha Swaminathan Rutgers Robert Wood Johnson Medical School

Subject: Practice-Based Approach to Resolving Maternal Mortality and Morbidity in Racial Minorities

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Across industrialized nations, the United States has one of the highest maternal mortality rates and rates continue to rise;[1,2]" and

Whereas, A 2017 report from Maternal Mortality Review Committees within the CDC Foundation determined that 59% of pregnancy-related deaths were preventable;[3] and

Whereas, Though black mothers are just as likely to experience postpartum complications as white mothers, the black maternal mortality rate is three times higher;[4] and

Whereas, In a New York City based studied, severe maternal morbidity was significantly greater in Hispanic women than non-Hispanic white women (2.7% vs 1.5%, p<.001);[5] and

Whereas, These racial disparities in maternal health persist even when controlling for education and SES; in fact, college-educated black women suffer from a greater rate of life-threatening complications during delivery compared to white women who never graduated high school;[6] and

Whereas, Due to the chronic stress of coping in a racialized society, women of color experience a higher degree of allostatic load than white women, making racial minorities more vulnerable to complications during and after pregnancy;[7,8] and

Whereas, Peripartum and postpartum care for women of color is also directly impacted by implicit bias in healthcare, evidenced by studies showing insufficient pain management in black and Hispanic women compared to white women, and lower efficacy of communication between physicians and black patients;[8-12] and

Whereas, Women of color who experience such racial discrimination during birth hospitalization "had more than twice the odds of postpartum visit nonattendance," which is further exacerbated by culturally-derived mistrust in the healthcare system;[12-14] and

Whereas, Clinical safety modifications using methods such as triggers, safety bundles, protocols, and checklist have strong supporting evidence for improving patient care in a variety of clinical settings, and are projected to benefit diagnosis and treatment of at risk pregnant women if integrated into maternal health;[15] and

Whereas, Council on Science and Public Health (CSAPH) Report 3-A-09, Disparities in Maternal Mortality, found that the Commission to End Health Care Disparities was the most appropriate body to work on disparities in maternal mortality, and recommended that the AMA work exclusively through the Commission to "evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States," which was codified as D420.993 in AMA policy;[16] and

Whereas, While the Commission to End Health Care Disparities provided broad strategies to tackle racial disparities in a clinical setting, the Commission did not release any recommendations specific to ameliorating health disparities in maternal mortality, and therefore did not fulfill the request of CSAPH Report 3-A-09;[17] and

Whereas, At Annual A-18, the Women Physicians Section responded to the progressively worsening statistics of maternal mortality in racial minorities by appending D-420.993 with policy intended to identify barriers and strategies to implement evidence based practice changes regarding maternal health and obstetric outcomes in racial minorities; and

Whereas, The AMA-MSS has devoted attention to health disparities in infant mortality and opposes decreases in funding to maternal and child health programs (254.012MSS, 150.003MSS), but currently lacks explicit policy recognizing and directing action on maternal mortality in racial minorities and the contribution of implicit biases to maternal outcomes; therefore be it

RESOLVED, That our AMA-MSS encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to maternal morbidity and maternal mortality in racial and ethnic minorities.

Fiscal note: Minimal, 5

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Disparities in Maternal Mortality D-420.993
Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US;

(3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

State Maternal Mortality Review Committees H-60.909
Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Medical Care for Indigent and Culturally Displaced Obstetrical Patients and their Newborns H420.995
Our AMA (1) reaffirms its long-standing position regarding the major importance of high-quality obstetrical and newborn care by qualified obstetricians, family physicians, and pediatricians and the need to make such care available to all women and newborns in the United States; (2) favors educating the public to the long-term benefit of antepartum care and hospital birth, as well as the hazards of inadequate care; and (3) favors continuing discussion of means for improving maternal and child health services for the medically indigent and the culturally displaced.

Infant Mortality D-245.994
1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.

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

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

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

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

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

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

Hunger in America 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.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 43
(I-18)

Introduced by:	Charlotte George, Paige Blinn, Ian Motie, Florida State University College of Medicine
Subject:	Mandatory Reporting of Sexual Misconduct Allegations to Law Enforcement
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, The Federation State Medical Boards defines “sexual violations” as “engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual;”[1] and

Whereas, A 2016 study determined 70% of physicians with sexual misconduct reports were not disciplined with legal or licensure ramifications by state medical boards, [2] and

Whereas, Only 11 states have laws requiring their state medical boards to report sexual violations to law enforcement when the victim is an adult,[1,3] and

Whereas, This loophole allows hospitals and healthcare organizations to privately terminate physicians without reporting their incidents of sexual violations to the police or licensing agencies;[3] therefore, be it

RESOLVED, Our AMA-MSS support the requirement of all state medical boards to report sexual misconduct allegations by physicians to the appropriate law enforcement agencies.

Fiscal note: Minimal, 4

Date received: 09/02/18

References:

1. DuBois JM. *et al*. Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases. *Sex Abuse.* 2017:1079063217712217.
2. AbuDagga A. *et al*. Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003-2013. *PLoS One.* 2016;11(2):e0147800.
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RELEVANT AMA AND AMA-MSS POLICY:

Addressing Barriers to Reporting Health Care Provider Sex Crimes H-515.954
Our AMA will support the efforts and work with the Federation of State Medical Boards to examine disciplinary data, barriers that delay or prevent reporting of sex crimes, and the cooperation of state medical boards with law enforcement in order to ensure a comprehensive approach to identifying and addressing sexual crimes within medicine.

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

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

Promoting Transparency to Stimulate Improved Quality 270.022 MSS
AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making. (MSS Res 13, A-10) (AMA Policies Reaffirmed in Lieu of AMA Res 808, I-10) (Reaffirmed, MSS GC Rep D, I-15)

Sexual Assault Survivors' Rights 515.010MSS
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 44
(I-18)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville, SC

Subject: Addressing disparities related to breast cancer differences between African American women and other women

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, African Americans make up 12% of the population in the United States, being the second largest ethnic/minority group in the United States and are a considerable group to address[1], and

Whereas, African American women face health disparities as both women and racial minorities[2], and

Whereas, The death rate for all cancers combined was 14% higher in African American women than in white women[3], and

Whereas, Breast cancer accounts for the highest incidence and second-highest death rate among cancers in African American women[4,5], and

Whereas, Despite lower incidence rates for breast cancer, black women have a death rate for this cancer that is 42% higher than white women[4], and

Whereas, Only about half (52%) of breast cancers in African American women are diagnosed at a local stage, compared to 63% in white women; this later stage diagnosis contributes to the lower 5-year survival rate of African American women compared to white women[4], and

Whereas, Lower stage-specific survival has been explained in part by unequal access to and receipt of prompt, high-quality treatment among black women compared to white women[6], and

Whereas, There is evidence that aggressive tumor characteristics are more common in breast cancers diagnosed in African American women than other racial/ethnic groups[7], and

Whereas, 22% of breast cancers in black women are referred to as triple negative (ER-, PR-, and HER2-) compared to 10-12% of those among women of other races/ethnicities in the US[7], and

Whereas, These differences in incidences are even higher among premenopausal black breast cancer patients[8], and

Whereas, Triple negative breast cancers are more aggressive and have poorer prognosis, in part because there are currently no targeted therapies for these tumors[9,11], and

Whereas, Triple negative breast cancer is more aggressive than and has a different underlying biology to that of receptor-positive breast cancers, and 38% of all deleterious mutations were detected in patients with triple negative breast cancer diagnosed at age < 40 years, pre-dating the USPFTF recommended starting age for mammography[10,11,12,13], and

Whereas, The disparity in survival rates of African American women with breast cancer compared to white women exists even after adjusting for socioeconomic status[14], and

Whereas, Pre-menopausal African American women have a higher prevalence of breast cancer (39%) than post-menopausal African American women (14%) and non-African American women (16%)[15], and

Whereas, African American women are more likely to be diagnosed with triple negative breast cancer as a result of African ancestry, and profiling of African American women with breast cancer revealed that 22% had at least one clinically relevant mutation[16,17], and

Whereas, AMA policy H-350.972 supports the 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; and

Whereas, AMA policy D-55.997 encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment; and

Whereas, AMA Code of Medical Ethics Opinion 8.5 supports 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; therefore be it

RESOLVED, That our AMA recognize African American women as a specific minority group that requires further research and funding in breast cancer disparities; and be it further

RESOLVED, That our AMA support research to better understanding the higher incidence of triple-negative breast cancer in African American women to better target treatment for them; and be it further

RESOLVED, That our AMA recognize that breast cancer diagnosis trends in black women have indicated need for further research regarding racial disparities in breast cancer diagnosis and management.

Fiscal Note: Moderate, 8

Date Received: 09/02/2018

References:

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2. Geronimus, AT. “The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations.” *Ethnicity & Disease*, vol. 2, no. 3, 1 Jan. 1992, pp. 207–221.
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4. Surveillance, Epidemiology and End Results (SEER) Program (www. seer.cancer.gov) SEER*Stat Database: NAACCR Incidence - CiNA Analytic File, 1995-2012, Custom File With County, North American Association of Central Cancer Registries
5. Surveillance, Epidemiology, and End Results (SEER) Program (www. seer.cancer.gov) SEER*Stat Database: Mortality – All COD, Aggregated With State, Total U.S. (1969-2012) , National Cancer Institute, DCCPS, Surveillance Research Program, Surveillance Systems Branch, released April 2015. Underlying mortality data provided by NCHS (www.cdc.gov/nchs).
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10. Couch, Fergus J, et al. “Inherited Mutations in 17 Breast Cancer Susceptibility Genes Among a Large Triple-Negative Breast Cancer Cohort Unselected for Family History of Breast Cancer.” *J Clin Oncol*, vol. 33, no. 4, Feb. 2015, pp. 304–311.
11. Tammemagi, C Martin. “Racial/Ethnic Disparities in Breast and Gynecologic Cancer Treatment and Outcomes.” *Current Opinion in Obstetrics and Gynecology*, vol. 19, no. 1, Feb. 2007, pp. 31–36.
12. Payne, Richard, et al. “Quality of Life Concerns in Patients with Breast Cancer.” *Cancer*, vol. 97, no. S1, 2002, pp. 311–317., doi:10.1002/cncr.11017.
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18. Dietze, Eric C, et al. “Triple-Negative Breast Cancer in African-American Women: Disparities versus Biology.” *Nat Rev Cancer*, vol. 15, no. 4, Apr. 2015, pp. 248–254.

RELEVANT AMA AND AMA-MSS POLICY:

Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities;

Racial and Ethnic Disparities in Health Care H-350.974
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

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.

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.

(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.

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.

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.

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment.

Screening and Education Programs for Breast and Cervical Cancer Risk Reduction MSS-55.003
AMA-MSS will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2) support government funded programs available for low income women; and (3) support the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer. (AMA Amended Res 418, I-91 Adopted [H-55.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (H-55.985 Rescinded: CCB/CLRPD Rep. 3, A-14)

Evaluation of the Principles of the Health Care Access Resolution MSS-165.009
(3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters;MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 45
(I-18)

Introduced by: Harleen Marwah, Sowmya Mangipudi, The George Washington University School of Medicine and Health Sciences

Subject: Be the change: implementing AMA climate change principles through JAMA paper consumption reduction and green healthcare leadership

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The World Health Organization has declared Climate change is the greatest threat to global health in the 21st century with expected consequences including the spread of disease, drought, and forced migration due to expected weather events[1]; and

Whereas, The American Medical Association has adopted policy in support of initiatives that promote environmental sustainability and efforts to halt global climate change, with board member Dr. Willarda V. Edwards explaining, “Scientific surveys have shown clear evidence that our patients are facing adverse health effects associated with climate change. From heat-related injuries and forest fire air pollution, to worsening seasonal allergies and storm-related illness and injuries, it is important that we make every effort to put environmentally friendly practices in place to lessen the harmful impact that climate change is having on patient health across the globe.”[2]; and

Whereas, Despite the gravity and medical relevance of these phenomena, there is a lack of clarity on the roles of health professionals, organizations and governments in responding to, or implementing, policies and action plans in this vital area; and

Whereas, the AMA has put forth the following policies: H-135.923 AMA Advocacy for Environmental Sustainability and Climate and H-135.938 Global Climate Change and Human Health

Whereas, the AMA has published that physicians should “Communicate with patients digitally...Communicating with patients through text, email and telephone can help increase access to care, save patients time and fuel cost, and help reduce the overall footprint of obtaining care,”[3] and,

Whereas, within the same publication, the AMA recommends to medical practices and facilities to “Print double-sided or go paperless with an electronic health record. Use a digital fax system in which fax images are received through email instead of on paper,”[4] and

Whereas, the Journal of the American Medical Association (JAMA) is an editorially independent but associated and reflective publication of the principles of the AMA,[5] and

Whereas, JAMA currently automatically enrolls members of the MSS in a weekly hard-copy subscription in addition to sending an online copy via email to MSS members, and

Whereas be it reducing the number of printed pages could save JAMA and the AMA a substantial amount of money that could be allocated to other AMA policy priorities, in compliance with the AMA's advice to physicians that "Implementing procedures and policies to help your medical practice save energy, reduce costs and increase efficiencies can be relatively easy to accomplish and inexpensive"[6]

Whereas, reduction in paper waste by eliminating redundant hard copy subscription would reduce the AMA's carbon footprint and comply with the AMA Journal of Ethics and American College of Physicians recommendation that "physicians should support policies that could help mitigate the health consequences of climate change and advocate for environmentally sustainable practices to be implemented in health facilities,"[7]; therefore be it

RESOLVED, that our AMA (a) shift existing all-inclusive paper JAMA to opt-in paper JAMA subscriptions by the year 2020, still giving students an option to receive paper JAMA, while reducing AMA paper waste, supporting a green initiative, and saving cost. (b) Money saved from reduced paper and printing should be directed to support medical student research in climate change and health.

Fiscal Note: Significant, 10

Date Received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY

H-135.923 AMA Advocacy for Environmental Sustainability and Climate; 1. Our AMA 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.

H-135.938 Global Climate Change and Human Health; 1. Our AMA 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.

H-135.921; AMA to Protect Human Health from the Effects of Climate Change by Ending its Investment in Fossil Fuel Companies; 1. Our AMA will choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations

that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption. 2. Our AMA will support efforts of physicians and 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.

H-135.977 Global Climate Change - The "Greenhouse Effect"; 1. Our AMA endorses the need for additional research on atmospheric monitoring and **climate** simulation models as a means of reducing some of the present uncertainties in **climate** forecasting;2. urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; 3. endorses increased recognition of the importance of nuclear energy's role in the production of electricity; 4. encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and 5. encourages humanitarian measures to limit the burgeoning increase in world population.

H-135.973; Stewardship of the Environment; 1. The AMA 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 46
(I-18)

Introduced by: Region 4

Subject: Amendment to H-170.967 and D-60.994 for Inclusion of Comprehensive Sexual Health Education for Incarcerated Juveniles

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, There is still a need to address the high rates of STIs and high-risk sexual practices in detained adolescents;[1] and,

Whereas, Incarcerated juveniles have high rates of risky sexual behavior, with one in four reporting never using condoms and approximately 20% having a current diagnosis of one or more sexually transmitted diseases;[2] and,

Whereas, Rates of sexually transmitted infections (STIs), such as chlamydia and gonorrhea, are higher among incarcerated juveniles than among imprisoned adults;[3] and,

Whereas, Condom use and knowledge about risky sexual behaviors is lacking among all youth, and these are even lower amongst incarcerated youth;[4] and,

Whereas, Individuals who communicated with partners about sexual history were more likely to use condoms;[5] and,

Whereas, Many juvenile correctional facilities do not provide comprehensive sexual health education due to cultural pressure and regulations against “delivering explicit messages and distributing materials such as condoms,” and the majority of condoms distributed to incarcerated youth were given at time of release;[6] and,

Whereas, Studies show that providing comprehensive sexual health education and removing barriers to resources such as condoms, and teaching youth to communicate about sexual health increases condom use, can help prevent unwanted STIs, delay onset of intercouse, prevent pregnancy, and the combination of education and resources does not increase sexual activity among youth;[7,8] and,

Whereas, A 2017 study indicated that youth detention-based prevention programs should emphasize sexual risk reduction strategies as a means to reduce risky behaviors for this population;[9] and,

Whereas, Interprofessional Student-Led Reproductive Health Education improved knowledge regarding sexually transmitted infections as well as self-reported confidence in condom use for youths in juvenile detention;[10] and,

Whereas, A recent intervention in 2017 involving individual and phone consultations for detained African American adolescent girls showed improvement in condom use skills and psychosocial outcomes;[11] and,

Whereas, The AMA supports "...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…" in schools (H-170.968);

Whereas, Both the AMA and the Society of Adolescent Medicine endorse screening and prevention for sexually transmitted diseases among incarcerated juveniles (D-60.994);[8] and,

Whereas, The AMA supports the education of "female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases, and HIV/AIDs, and also supports the availability of intervention programs for girls who have been victimized" (H-170.967); and,

Whereas, The AMA "encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services (H-60.919); therefore be it,

RESOLVED, That our AMA amend H-170.967 by substitution and addition as follows:

> Rehabilitative Programs, Mental Health, and Educational Services for ~~Girls~~ Adolescents in the Juvenile Detention System. H-170.967
> Our AMA supports comprehensive health education for ~~female delinquents~~ all incarcerated adolescents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for ~~girls~~ all adolescents who have been victimized.

RESOLVED, That our AMA amend D-60.994 with addition as follows:

> Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles D-60.994
> Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening, education, and treatment for sexually transmitted infections and sexual abuse.

RESOLVED, That our AMA oppose regulations that deny incarcerated juveniles access to sexual health education and condoms.

Fiscal note: Minimal, 6

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Sexually Transmitted Infections Among Adolescents, Including Incarcerated Juveniles D-60.994
Our AMA will increase its efforts to work with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted infections and sexual abuse.

Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System. H-170.967
Our AMA supports comprehensive health education for female delinquents, including information on responsible sexual behavior, the prevention of sexually transmissible diseases and HIV/AIDS, and also supports the availability of intervention programs for girls who have been victimized.

Juvenile Justice System Reform. H-60.919
Our AMA:
1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance' policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

Update on Sexually Transmitted Infections. H-400.983
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.

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

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 sexualtransmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
(9) Supports the development of sexualeducation 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
(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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 47
(I-18)

Introduced by:	Dana Benyas, Fiona Clowney, Jessica Johns, Connor Beuchler, Tabitha Moses, Elana Folbe, Wayne State University School of Medicine
Subject:	Legalization of Consensual Sex Work
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Sex work is defined as a sexual service offered in exchange for money or other benefits and legalization of sex work would entail conferring official legal status on the practice of prostitution, allowing more regulatory control than mere decriminalization;[35, 1] and

Whereas, The World Health Organization (WHO), UNFPA, UNAIDS, the Global Network of Sex Work Projects, Amnesty International and Human Rights Watch all recommend decriminalization of consensual sex work to improve access to health care for high risk populations, with the WHO specifying that decriminalization would help reduce HIV incidence by improving access to healthcare;[2, 3, 34] and

Whereas, Sex work is currently legal in the United Kingdom, Belgium, Argentina, Denmark, Israel, the Netherlands, New Zealand, Spain, Switzerland, Singapore, and the U.S. state of Nevada;[4-10] and

Whereas, A systematic review of the literature estimates that 15-20% of men in the United States have paid for sex at least once;[11] and

Whereas, Rates of STIs (e.g. chlamydia, gonorrhea, and syphilis) in the U.S. reached an all-time high in 2016 with nearly 2.3 million new cases;[12] and

Whereas, Studies in Australia found that where criminal laws had been removed, there were statistically significant decreases in rates of HIV and sexually transmitted infection and increases in rates of condom use;[13 - 15] and

Whereas, A study in Australia revealed that 50% of illegal sex workers and only 13% of legal sex workers were offered more money to have sex without a condom;[16] and

Whereas, Following an accidental decriminalization of indoor prostitution in 2003 in Rhode Island, reported rapes declined 30% and gonorrhea declined over 40% not only for sex workers, but for the overall community;[17] and

Whereas, In countries where sex work is criminalized, sex workers are less likely to seek treatment if they get infected with an STI;[18] and

Whereas, Sex workers in the U.S. struggle to obtain health insurance since their primary income is through illegal means, lending to the majority not having health insurance and paying out of pocket for healthcare;[19] and

Whereas, 75% of all transgender murder victims in Europe were sex workers and in the U.S. transgender sex workers are more likely to postpone medical care than transgender people working in other professions;[20, 21] and

Whereas, 33,309 people, many of whom are parents, were arrested for prostitution and commercial vices in 2016, putting their children at an increased risk for depression, anxiety, antisocial behavior, drug use, and cognitive delays;[22, 23, 30] and

Whereas, In a study on the mental health of legal versus illegal sex workers in Australia, unlicensed sex workers were 4 times more likely to report mental health issues compared to legal sex workers, possibly due to an increased risk of assault and arrest;[16] and

Whereas, In the same study, illegal sex workers were 4.5 times more likely to have used injection drugs than legal sex workers;[16] and

Whereas, Legalization of sex work would allow for sex worker union formation, a measure shown to decrease income inequality, improve working conditions, and better the health of union and non-union members, as was the case with the formation of the Exotic Dancers Union;[24 - 26] and

Whereas, The 2018 Fight Online Sex Trafficking Act (FOSTA) prohibits solicitation of consensual sex workers despite internet-vetted sex work causing lower rates of STIs, less reliance on exploitative pimps, and less violence by dangerous clients;[27,28] and

Whereas, A recent systematic review found lifetime prevalence of workplace-based violence among sex workers to be 45-75% and a study of prostitutes in New York City showed 27% had experienced violence by policemen and 17% reported sexual harassment, including rape, by policemen;[29, 30] and

Whereas, In Australia, 52% of illegal sex workers had been raped by a client in the prior year compared to 9% of legal sex workers;[16] and

Whereas, A recent study of sex workers in Chicago who had a pimp found that over half had experienced coercive violence with increasing levels of violence since recruitment;[31] and

Whereas, Research on the regulation, scrutiny, and bureaucratization allowed by legalized prostitution in Nevada shows that legalization reduces violence against prostitutes, violence against community order, and STIs;[33] and

Whereas, Sex work repression and the potential for arrest does not stop sex work but drives it into more covert forms whereby violence from pimps and clients is perpetrated with impunity;[32, 2] and

Whereas, Existing AMA policy states, “Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex

trafficking of minors by promoting care and services for victims instead of arrest and prosecution" (H.60.912); therefore, be it

RESOLVED, That our AMA support the legalization of consensual sex work.

Fiscal note: Moderate, 7

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods H-515.958
Our AMA supports efforts to offer opportunities for a safe exit from the exchange of sex for money or goods if individuals choose to do so, and supports access to compassionate care and "best practices". Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration.

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential

complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(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;
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
(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 the exchange of sex for money or goods.

Physicians Response to Victims of Human Trafficking H-65.966
1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

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

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

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

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

Human Trafficking / Slavery Awareness D-170.992
Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Legal Protection and Social Services for Commercially Sexually Exploited Youth. 60.023MSS
That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (MSS Res 40, A-14) (MSS Res 4, I-14 Adopted as Amended [D-60.969])

Global HIV/AIDS Prevention 250.019MSS
AMA-MSS will ask the AMA to (1) support 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; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (MSS Late Res 3, A08) (AMA Res 438, A-08 Withdrawn) (Reaffirmed: GC Rep B, I-13)

The Identification and Protection of Human Trafficking Victims 515.008MSS
AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking.

Advocating for Optimal Screening and Management of Human Trafficking Victims by Formal Education of Healthcare Professionals on this Issue through Integration of this Topic into Continuing Medical Education Requirements and Undergraduate Medical Curriculum throughout the USA: The MSS formally establishes support for the following HOD policy: H-65.966 Physicians Response to Victims of Human Trafficking
Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking. Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims. The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers

forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children. The Polaris Project - In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project: - Operates a 24- hour National Human Trafficking Hotline - Maintains the National Human Trafficking Resource Center, which provides a. An assessment tool for health care professionals b. Online training in recognizing and responding to human trafficking in a health care context c. Speakers and materials for in-person training d. Links to local resources across the country The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. (BOT Rep. 20, A-13)

Sexual Assault Survivors' Rights 515.010
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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 48
(I-18)

Introduced by: Yash Shah, Kunj Jain, Rutgers – New Jersey Medical School; Neil Jain, Rowan University School of Osteopathic Medicine

Subject: Implementing Elective Rotations and Increasing Exposure to Prisons into the Medical Education Curriculum

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Mass incarceration in the U.S. still remains a huge public health issue as it affects two million people currently in the prison system despite the fact that the incarceration rate has been slowly declining in the past decade;[1] and

Whereas, These environments carry health disparities with them when compared to the general public as the prevalence of serious mental illness (SMI) is two to four times higher in state prisons than the general population, 50% of all people in state prisons have diagnosable substance use disorders, and Hepatitis C, HIV, and AIDS are at least 2 to 8 times more prevalent in correctional facilities;[2] and

Whereas, 68.4% of jail inmates had not received a medical examination since incarceration and 40% of those who were taking a prescription medication prior to incarceration stopped the treatment following incarceration;[3] and

Whereas, Existing AMA Policy (Health Care While Incarcerated, H-430.986) supports collaboration between the prison system and healthcare system; thus, medical education should be proactive in these issues in producing physicians who are experienced advocates that have worked with those who are currently incarcerated, as illustrated by University of Wisconsin's Correctional Health Care elective (Health Care While Incarcerated policy); and

Whereas, Research has shown that students in the medical fields generally have positive experiences in rotations at correctional facilities as shown by the fact that 74% of medical students in a one-day induction program at a high security hospital reported having had a positive experience and 99% of nursing students in a clinical rotation at an all-male security prison recommended continuing the experience at the prison;[4-7] and

Whereas, Academic Medical Centers can fulfill their mission regarding the treatment of disadvantaged populations by partnering with correctional facilities to help reduce healthcare disparities and provide medical students and residents with opportunities of caring for these disadvantaged populations as shown by AMC's in New Jersey, Connecticut, Georgia, and Texas partnering with correctional facilities;[8-9] therefore be it

RESOLVED, That our AMA advocate for elective rotations and exposure to the prison healthcare system to be implemented in the medical education curriculum.

Fiscal Note: Significant, 12

Date Submitted: 09/23/2018

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RELEVANT AMA AND AMA-MSS 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

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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 49
(I-18)

Introduced by:	Region 5; Ryan Chiu, University of Illinois College of Medicine; Ellena Popova, University of Pennsylvania Perelman School of Medicine; Shiri Nawrocki, Rutgers-Robert Wood Johnson Medical School
Subject:	Support The Widespread Distribution of Naloxone Boxes Throughout the Country
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, In the USA in 2017, drug related deaths exceeded 72,000 people, of which 49,068 were opioid related leading to 115 opioid overdose deaths per day, the highest in U.S. history;[1,2] and

Whereas, The prevalence of diversion and misuse of both prescription and non-prescription opioids has increased significantly in prevalence over the past decade, with overdoses increasing almost 30% from July 2016 to September 2017;[3] and

Whereas, Opioid misuse has been associated with excess annual healthcare expenditures of up to $20,000 per person on private insurance and up to $15,000 for those on Medicaid with the CDC reporting the total economic burden of prescription opioid misuse in the US are $78.5 billion;[4,5] and

Whereas, Naloxone is an opioid receptor antagonist that reverses the effects of opioid agents, has no potential for abuse, and is harmless to those not experiencing opioid overdose;[6,7] and

Whereas, NaloxBoxes are a bystander friendly kit designed to accommodate 4 doses of Naloxone, 1 rescue breaths mask, and an information card on accessing addiction treatment;[8] and

Whereas, Naloxone boxes are being used throughout Rhode Island and are being considered in Massachusetts to provide easily accessible naloxone in high-risk areas;[9,10] and

Whereas, A recent feasibility study on public access naloxone kits found that the bystanders in a simulated environment were willing to administer naloxone and 98% did so correctly;[11] and

Whereas, The community placement of naloxone boxes is analogous to the widespread distribution of AEDs in public spaces;[10,12] and

Whereas, State laws manage how to own, place, and use AEDs, including 1) AED placement mandates requiring certain types of organizations to own AEDs, 2) Good

Samaritan Immunity protecting those who use AEDs in emergent situations against negligence, and 3) general AED law requirements including selecting those who must be trained in use AEDs, administering AED programs managed by the American Heart Association, maintaining AEDs, reporting AED use;[14] and

Whereas AED placement mandates require any health club, gymnasium, or school event to have an AED on site and its employees trained to use an AED including physicians, nurses, emergency medical technicians, paramedics, police officers, firefighters, teachers, and school employees;[15] and

Whereas, The average cost per AED was 2460 US dollars, the cost per life resuscitated was 52,400 US dollars;[16] and

Whereas, Although there are no current estimates of the cost of naloxone box kits, generic naloxone costs between $20 and $40 and research shows that naloxone distribution for overdose reversal is cost effective;[8,10,17] and

Whereas, A community naloxone distribution and training program in Massachusetts reduced opioid overdose deaths by an estimated 11 percent, without simultaneously increasing opioid use, in the communities that implemented it;[20] and

Whereas, Although 43 states in the United States and the District of Columbia have passed Naloxone laws to dispense and administer the drug without a prescription, the remaining states of continue to have restrictions of accessibility and some still require a prescription to obtain the medication;[21,22] and

Whereas, There are currently 36 states that do not remove criminal liability for possession of naloxone without a prescription and 15 states where naloxone dispensers do not immunity from criminal prosecution for prescribing, dispensing or distributing naloxone to a layperson;[23] and

Whereas, Restrictions to naloxone access typically question the safety of its pharmacological properties and administration procedures, and the potential for higher-risk drug use practices; however, available data suggests that these concerns are largely unfounded, and that any potential risks are outweighed by benefits;[24] therefore be it

RESOLVED, That our AMA support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription; and be it further

RESOLVED, That the AMA to amend policy H-95.932 (Increasing Availability of Naloxone) by insertion and deletion as follows:

> 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.
8. Our AMA advocate for the widespread implementation of easily accessible naloxone rescue stations throughout the country following similar distribution and legislation as AEDs
~~8. Our AMA urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).~~

Fiscal note: Moderate, 10

Date received: 09/23/18

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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.
8. Our AMA urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

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.
3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

911 Good Samaritan Laws D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

Naloxone Administration and Heroin Overdose 100.007MSS
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
3. Work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
AMA-MSS will ask the AMA to:
1. Encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone
2. Advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities

OTC Availability of Naloxone 100.013MSS
AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone.

Naloxone Administration and Heroin Overdose 100.007MSS
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
3. Work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine

Promoting Prevention of Fatal Opioid Overdose 100.010MSS
AMA-MSS will ask the AMA to:
1. Encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone
2. Advocate for encourage the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities

OTC Availability of Naloxone 100.013MSS
AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 50
(I-18)

Introduced by: Region 5; Shiri Nawrocki, Rutgers-Robert Wood Johnson Medical School

Subject: Equalizing End of Life Care for People with Disabilities

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, In 2013, there were approximately 1.5 million adults in the USA with a disability (either developmental or acquired) severe enough to warrant guardianship;[1] and

Whereas, In most states, the guardianship process involves the court appointment of a guardian for the individual with intellectual disability, as well as documentation from healthcare professionals attesting to the individual's diminished ability to make some or all of their own life decisions;[2] and

Whereas, Guardianship confers the responsibilities of decision-making that the caregiver must accept in lieu of direct patient consent;3 and

Whereas, Different jurisdictions have defined capacity for consent among individuals with disabilities across different areas, such as with regards to consenting for sexual activity or for participation in research;[4] and

Whereas, Many basic criteria must be met in order to be considered as meeting the burden of capacity for consent, including voluntariness, safety, situational appropriateness, ability to withdraw consent, and protection from exploitation and abuse;[4] and

Whereas, The largest national community organization advocating for people with intellectual and developmental disabilities—The Arc—states that people with intellectual and developmental disabilities should be afforded the same rights, dignity, respect, and opportunities as older people in order communities including appropriate end-of-life care;[5] and

Whereas, The American Association on Intellectual and Developmental Disabilities, supports the stance that although caregivers should always act to promote and sustain life, there are situations in which continued life is not in someone's best interest;[6] and

Whereas, Advanced directives are limited to persons that are of deemed of sound mind, which does not include persons under guardianship;[7] and

Whereas, Only five states have explicit statues that allow guardians to make end-of-life decisions without judicial approval if specific criteria are met, and 37 states have no explicit language about the guardians ability to consent to end of life care;[8] and

Whereas, The statutes in eight states explicitly prohibit a guardian from making end-of life decisions without a court order, and a further three states only allow the guardian to consent to

withdrawal of life-sustaining treatment is the ward had previously completed an advanced directive;[8] and

Whereas, Studies have shown that people with intellectual disabilities are often excluded from discussion about their own end-of-life care, and may not receive adequate end-of-life care even in states where no official state laws prohibits guardians from signing advanced directives;[9,10,11] and

Whereas, The Federal Patient Self-Determination Act of 1991 requires that institutions receiving federal Medicare or Medicaid funding inform all patients of their rights to execute advances directives;[12] and

Whereas, Guardianships are limited as much as is reasonable to allow the highest degree of personal autonomy to a ward while also offering the greatest dignity and right to determinism over decisions;[13]

Whereas, Current AMA policy supports the right of patient self-determination in deciding to forgo end of life care (H-140.966) and also supports the rights of all persons to receive equal rights in all areas of life including healthcare without regard to any personal characteristics including disability (H-65.965); therefore be it

RESOLVED, That our AMA will work with state medical societies to develop model legislation and protocols for self-determination in DNAR and Advanced Directives for those with developmental disabilities; be it further

RESOLVED, That our AMA support the right of guardians to make end of life decisions in situations deemed appropriate by the healthcare team

Fiscal note: Significant, 11

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Decisions Near the End of Life H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful

examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

(5) Our AMA supports continued research into and education concerning pain management.

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.

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.
10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

5.4 Orders Not to Attempt Resuscitation (DNAR)
The ethical obligation to respect patient autonomy and self-determination requires that the physician respect decisions to refuse care, even when such decisions will result in the patient’s death. Whether a patient declines or accepts medically appropriate resuscitative interventions, physicians should not permit their personal value judgments to obstruct implementation of the patient’s decision.
Orders not to attempt resuscitation (DNAR orders) direct the health care team to withhold resuscitative measures in accord with a patient’s wishes. DNAR orders can be appropriate for any patient medically at risk of cardiopulmonary arrest, regardless of the patient’s age or whether or not the patient is terminally ill. DNAR orders apply in any care setting, in or out of hospital, within the constraints of applicable law.
In the event a patient suffers a cardiopulmonary arrest when there is no DNAR order in the medical record, resuscitation should be attempted if it is medically appropriate. If it is found after the code is initiated that the patient would not have wanted resuscitation, the attending physician should order that resuscitative efforts be stopped.

Physicians should address the potential need for resuscitation early in the patient's course of care, while the patient has decision-making capacity, and should encourage the patient to include his or her chosen surrogate in the conversation. Before entering a DNAR order in the medical record, the physician should:
(a) Candidly describe the procedures involved in resuscitation, the likelihood of medical benefit in the patient's clinical circumstances, and the likelihood of achieving the patient's desired goals for care or quality of life to address any misconceptions the patient may have about probable outcomes of resuscitation.
(b) Ascertain the patient's wishes with respect to resuscitation—directly from the patient when the individual has decision-making capacity, or from the surrogate when the patient lacks capacity. If the patient has an advance directive, the physician should review the directive with the patient and confirm that the preferences set out in the directive about resuscitation are current and valid. The DNAR order should be tailored to reflect the particular patient's preferences and clinical circumstances.
(c) Reinforce with the patient, loved ones, and the health care team that DNAR orders apply only to resuscitative interventions as they relate to the patient's goals for care. Other medically appropriate interventions, such as antibiotics, dialysis, or appropriate symptom management will be provided or withheld in accordance with the patient's wishes.
(d) Revisit and revise decisions about resuscitation—with appropriate documentation in the medical record—as the patient's clinical circumstances change. Confirm whether the patient wants the DNAR order to remain in effect when obtaining consent for surgical or other interventions that carry a known risk for cardiopulmonary arrest and adhere to those wishes.
(e) Document in the medical record the patient's clinical status, prognosis, current decision-making capacity, and preferences with respect to resuscitation, as well as the physician's medical judgment about the appropriateness of resuscitation.
When the patient cannot express preferences regarding resuscitation or does not have decision-making capacity and has not previously indicated his or her preferences, the physician has an ethical responsibility to:
(f) Candidly and compassionately discuss these issues with the patient's authorized surrogate and document the surrogate's decision in the medical record.
(g) Revisit with the surrogate decisions about resuscitation as the patient's clinical circumstances change, revising the decision as needed and updating the medical record accordingly.
(h) Seek consultation with an ethics committee or other appropriate institutional resource if disagreement about a DNAR order that cannot be resolved at the bedside.
When the patient's preferences cannot be determined and the individual has no surrogate, the physician should consult with an ethics committee or other appropriate institutional resource before entering an order not to attempt resuscitation.

5.6 Sedation to Unconsciousness in End-of-Life Care
The duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients. When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation it can be appropriate to offer sedation to unconsciousness as an intervention of last resort.

Sedation to unconsciousness must never be used to intentionally cause a patient's death.
When considering whether to offer palliative sedation to unconsciousness, physicians should:

(a) Restrict palliative sedation to unconsciousness to patients in the final stages of terminal illness.
(b) Consult with a multi-disciplinary team (if available), including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment.
(c) Document the rationale for all symptom management interventions in the medical record.
(d) Obtain the informed consent of the patient (or authorized surrogate when the patient lacks decision-making capacity).
(e) Discuss with the patient (or surrogate) the plan of care relative to:
(i) degree and length of sedation;
(ii) specific expectations for continuing, withdrawing, or withholding future life-sustaining treatments.
(f) Monitor care once palliative sedation to unconsciousness is initiated.
Physicians may offer palliative sedation to unconsciousness to address refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control. Existential suffering should be addressed through appropriate social, psychological or spiritual support.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 51
(I-18)

Introduced by: Tristan Mackey and Haritha Pavuluri, University of South Carolina School of Medicine Greenville, SC

Subject: Utilizing Food Insecurity Screenings in the Emergency Medical Setting to Identify at Risk Individuals

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, 1 in 8 Americans faced some degree of food insecurity in 2016[3] and 72% of those individuals live at or below the federal poverty line[6]; and

Whereas, Current nutrition assistance programs are only used by 61% of food insecure households[1]; and

Whereas, 47% of individuals who utilize Feeding America services, such as food banks and nutritional assistance, report having poor or fair health[2,6], and of those, 53% have high blood pressure and 33% have diabetes[2,6]; and

Whereas, Prolonged insufficient food intake or malnutrition caused by a lack of access to food can increase the risk of hypertension, asthma, infection, birth defects, and behavioral issues[1]; and

Whereas, The frequency of emergency room visits correlates with the level of poverty[5]; and

Whereas, The rise of prevalence in increased health problems has led to an increase in medical care spending, which leads to trade-offs between buying food and paying medical bills[1]; and

Whereas, Healthcare providers, especially those in emergency medical settings, have a unique opportunity to identify food insecurity in patients and are trusted to advise patients to seek out nutritional resources[1]; and

Whereas, Food insecurity screening pilot programs, along with food prescription programs to local food banks and nutrition programs, have led to a 3% decline in emergency department usage and 53% reduction in readmission rates at ProMedica in Ohio[1]; and

Whereas, In 18 months, the Geisinger Health System's Fresh Food Farmacy has seen a 2.1% decrease in HbA1C levels in patients who were prescribed and provided fresh food[4]; and

Whereas, The Fresh Food Farmacy patients also had a significant reduction in cost of care for the management of their diabetes over the course of their time in the program[4]; and

Whereas, Our AMA-MSS supports the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals (AMA-MSS policy 215.003MSS); and

Whereas, Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems (AMA policy H-160.896); therefore be it

RESOLVED, That our AMA-MSS support partnerships between hospitals and local and national nutrition assistance programs in order to provide information and direct patients identified as food insecure to these resources, and be it further

RESOLVED, That our AMA-MSS encourages research into the effectiveness of food prescriptions and hospital based food assistance programs for those patients identified as food insecure.

Fiscal Note: Minimal, 5

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Preventive Screening and Treatment of Malnutrition in Hospital Patients 215.003MSS
AMA-MSS will ask the AMA to (1) support the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals; (2) support the establishment of national registries for the sharing of information on prevalence of malnutrition, health outcomes, costs, and other metrics associated with the performance of nutrition support teams and other preventive nutritional interventions; and (3) support the reimbursement of assessment and interventions provided by nutrition support teams as preventive services where they are used to

preclude or mitigate adverse health outcomes, rather than manage disease-related malnutrition. (MSS Res 29, I-13)

Identifying and Addressing Food Insecurity and Food Deserts Nationwide 150.034MSS
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)

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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 52
(I-18)

Introduced by	Region 5
Subject	Increasing Education regarding Transition Planning for Children with Chronic Health Conditions, not Limited to Those with Developmental Disabilities
Referred to	MSS Reference Committee (Lauren Engel, Chair)

Whereas, The number of children with chronic health conditions has increased by 400% in the last five decades, largely due to an increase in prevalence and improvements in diagnosis, rather than medical advancements in treatment and[1]

Whereas, 44% of children have a chronic condition, and up to 500,000 children with chronic health conditions turn 18 every year, necessitating the need for transition from pediatric to adult healthcare and[2]

Whereas, Many youth with chronic health conditions, including but not limited to developmental disability, neurological disease, congenital malformations, and genetic diseases, face several obstacles in transitioning into adult healthcare and adult life and[2,3]

Whereas, This dramatic increase in children surviving to adulthood is creating a situation in which there is often lack of communication, no common guidelines, and differences in the management of patients by internists compared to pediatricians and[3, 4]

Whereas, The transition into adulthood for children with chronic health conditions is complicated by disruptions in care during adolescence and adulthood, inadequate preparation by adult providers to manage the unique needs of these patients, and lack of coordination and communication between pediatric and adult primary and specialty care providers and[5]

Whereas, Lack of transition in care can lead to adverse outcomes, including patient disengagement, non-compliance to treatment, increased number of hospitalizations, and diminished health outcomes and[6]

Whereas, There are an estimated 4·5 million youth aged 12–18 with chronic health needs in the USA, but only 40% of them receive transitional services to adult health care, work, and independence and[7]

Whereas, The number of patients with chronic health conditions who have a personal doctor or nurse drops from 91.9% when the patient is aged 14-17 to 72.4% when the patient is aged 19-23 and[8]

Whereas, A joint statement by American Academy of Pediatrics and American Academy of Family Physicians, and the American College of Physicians stated as a goal that by 2010 “all physicians who provide primary or subspecialty care to young people with special health care needs [to] (1) understand the rationale for transition from child-oriented to adult-oriented health care; (2) have the knowledge and skills to facilitate that process; and (3) know if, how, and when transfer of care is indicated and”[9]

Whereas, Existing AMA policy (H-60.974) calls for the AMA to encourage physicians to establish management of their health issues, as necessitated by improving healthcare transition from pediatric to adult providers, especially among children with special health needs and to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system

Whereas, Existing AMA policy (H-165.855) calls for the AMA to ensure that as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage and

Whereas, The AMA-MSS (25.002MSS) asserts that the AMA should encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible and

Whereas, the above policies have been physician-centric in raising awareness about this issue, and focused on those with developmental disabilities, rather than illuminating the significant barriers youth with chronic health conditions face in transitioning from pediatric to adult providers, including logistical problems with transportation or insurance, lack of information for patients about options and possibilities, and decreased role for family members in the adult healthcare system, and[10, 11]

Whereas, The majority of youth with chronic health conditions are not offered sufficient discussion about transition to their adult health needs, in spite of the significant push from several specialty societies to encourage physicians to become more involved in transition planning and[11]

Whereas, No insurance reimbursements are available to providers for transition planning and coordination of care, creating another barrier for patients with long-term health conditions in navigating the health care system from childhood to adulthood and[11]

Whereas, Current research on long-term health outcomes of transition planning is limited, there are no standardization in outcome measures, and there are no studies that compare patient centric versus family centric transition plan models[12, 3]

Whereas, Only one-third of pediatricians provide referrals to adult providers and less than 15% report providing patients with educational materials regarding transition, creating a climate in which less than half of youth with chronic health conditions receive adequate transition services and[3]

Whereas, Ineffective of communication between pediatric and adult providers, such as use of written documentation only, can hamper the development of a relationship between adult providers and patients during the transition process and[13]

Whereas, 40% of adult health care providers felt uncomfortable caring for the young adult patients indicating a lack of education and knowledge of providing transitional care and[5]

Whereas, Data shows that the majority of youth with chronic health needs are not offered sufficient discussion about transition to their adult health needs, in spite of the significant push from several specialty societies to encourage physicians to become more involved in transition planning;[11] therefore be it

RESOLVED, That our AMA encourage increased medical education and training regarding transitioning care for youth with chronic health conditions, by advocating for incorporation of this topic into medical licensing exams; and be it further

RESOLVED, That our AMA lobby for increased reimbursements to providers who engage in transition planning; and be it further

RESOLVED, That our AMA support an increase in evidence-based research that helps to elucidate the effectiveness of transition planning on long term health outcomes for children with chronic illnesses; and be it further

RESOLVED, That our AMA support legislative efforts to create public information campaigns targeted towards patients, families, and providers, addressing the barriers to transition planning and ways to mitigate those barriers.

Fiscal Note: Significant, 12

Date Received: 09/23/18

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Existing AMA and AMA-MSS Policy

Children and Youth With Disabilities H-60.974

It is the policy of the AMA:
(1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations.

Medical Care for Patients with Low Incomes H-165.855

It is the policy of our AMA that:
(1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.
(2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
(3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
(4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment

opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.
(5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.
(6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.
(7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)
(8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.

Transitional Support for Individuals with Autism Spectrum Disorders into Adulthood 25.002MSS

AMA-MSS will as our AMA to encourage appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for adults with developmental delays, with the goal of independent function when possible. MSS Res 6, I-15; AMA Res 001, A-16; Adopted with Change in Title to “Support Persons with Intellectual Disabilities”

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION:

Resolution: 53
(I-18)

Introduced by: Yutong Dong, Shruti Gupta, Arjun Rangan, Daniel Alligood, Mevish Siddiq, Sachin Kothari; Medical College of Georgia, Augusta University

Subject: Public Health Awareness of Adverse Childhood Experiences

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, It is well-known that early life experiences and parental life adversity both shape developing brain architecture and lay the foundation for long-term health prognosis;[1-3] and

Whereas, Adverse childhood experiences include all forms of abuse, including sexual and physical, all forms of neglect, including physical and emotional, and household challenges, including parental separation/divorce, substance abuse disorder, and domestic violence;[4-6] and

Whereas, It is currently estimated that 1 in 6 children are sexually abused here in the United States;[6, 7] and

Whereas, Furthermore, other adverse childhood experiences continue to be highly prevalent public health issues; [6, 7] and

Whereas, Studies have shown that adverse childhood experiences have strong associations with elevated risks for future substance abuse disorder, suicide ideation and attempts, neurocognitive impairment, psychiatric conditions, cardiometabolic diseases, including hypertension and diabetes, and cancer;[4-14] and

Whereas, In Summer 2018, the AMA executive vice-president Dr. James Madara wrote in an open letter stating the AMA's position against family separation as a form of adverse childhood experience, which may negatively impact the entire lifespan of these children;[15] and

Whereas, Various types of adverse childhood experiences and their consequences remain understudied and under-promoted in public health awareness among the community, in the hospitals, and in schools; and

Whereas, Existing AMA-MSS policy [295.007MSS] recognizes the urgency for all US medical schools to include in their required curriculums both formal lectures and clinical instruction in the subject of child abuse and neglect; and:

Whereas, Existing AMA-MSS policy [295.079MSS] asks our AMA to continue its support for the education of medical students on domestic violence; and:

Whereas, Existing AMA policy [H-515.981] encourages physicians to screen adolescents for maltreatment, abuse, or neglect; therefore be it

RESOLVED, That our AMA-MSS will ask our AMA to encourage US medical schools and local AMA chapters to educate medical students, residents, fellows, and physicians on public health and clinical topics related to adverse childhood experiences: the different types of experiences, including but not limited to domestic violence, and their clinical identifications and manifestations, communication strategies to engage with patients about their experiences, and providing information on how these experiences may be associated with patients' health prognosis; and be it further

RESOLVED, That our AMA-MSS will ask our AMA to work with other health organizations to create, implement, and promote a national screening tool or guidelines for adverse childhood experiences on various age groups, including but not limited to adolescents, that can be utilized in the hospitals, clinics, and schools, and to work with other health organizations to support further research in areas related to adverse childhood experiences.

Fiscal Note: Significant, 12

Date Received: 09/23/18

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Relevant AMA and AMA-MSS Policy

Curriculum in Child Abuse and Neglect 295.007MSS
AMA-MSS will ask the AMA to urge all US medical schools to include in their required curriculums both formal lectures and clinical instruction in the subject of child abuse and neglect.

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.

Education of Medical Students About Domestic Violence Histories 295.079MSS
AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk. (AMA Amended Res 303, I-96

Adopted [H295.912]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 54
(I-18)

Introduced by: Region 5

Subject: Access to Healthcare Services Denied by Faith-Based Healthcare Organizations

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, One in six[1] Americans currently receives healthcare services in a faith-based health care organization, defined as a hospital or health care institution that is owned or operated by a religious organization and/or adheres to a code of ethics promulgated by a religious organization; and

Whereas, Many faith-based health care organizations restrict the ability of patients and physicians to access or provide health care services that those faith traditions find morally unacceptable, such as contraception[2,3,4], therapeutic or elective abortion for any purpose including to save the life of the mother[5], end of life care[5,6], or care of LGBTQ+ patients[1,6]; and

Whereas, The refusal of medically necessary care creates significant, potentially life-threatening adverse health outcomes to patients served by these institutions, and due to local geography, insurance billing issues, or local physician shortages, these patients may have to travel unreasonable distances or incur significant personal expense to access the care they require[1,7,8]; and

Whereas, The consolidation of healthcare organizations into regional and national networks, notably those controlled by faith-based organizations, creates unintended consequences for physicians and patients by imposing a new level of oversight from non-medical personnel that directly impacts delivery of patient care[1] and in many cases cannot be overcome by either physician or patient due to the aforementioned obstacles of time or expense; and

Whereas, The AMA Code of Medical Ethics enjoins physicians “to use sound medical judgment on their patients’ behalf, and to advocate for their patients’ welfare” and, in circumstances where physician conscience may render such medical judgment morally problematic, the physician is obligated “to honor patients’ informed decisions… and respect basic civil liberties” and “have stronger obligations… when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient’s physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician” (E-1.1.1; E-1.1.7); and

Whereas, Faith-based healthcare organizations, by abrogating the ability of physicians to provide health care that the patient wants and the physician believes is medically

necessary[1,3,9], violate the AMA Physician and Medical Staff Member Bill of Rights by preventing "the right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body"; therefore, be it

RESOLVED, That our AMA-MSS should oppose efforts of faith-based healthcare organizations to limit the right of patients and their physicians to decide on the care that they require for their health and well-being, and when that care cannot be provided by a faith-based healthcare organization, the patient should be provided with appropriate access to a physician or institution that can provide the required care.

Fiscal note: Minimal, 6

Date received: 09/02/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Physician and Medical Staff Member Bill of Rights H-225.942
1. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised

by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

Reproductive Health Care in Religiously-Affiliated Hospitals 5.006MSS
AMA-MSS (1) advocates that religiously-affiliated medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; and (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient. (MSS Res 13, A-17)

Mergers of Secular and Religiously Affiliated Healthcare Institutions H-140.832
AMA affirms the right of physicians who have held staff privileges at previously secular hospitals which have been purchased by religiously affiliated healthcare organizations to continue to provide care to their patients as their ethical beliefs dictate, including provision of care (such as contraception, abortion, or end of life care) that is proscribed by the religious organization involved in ownership of the healthcare facility.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 55
(I-18)

Introduced by: Region 5; Region 3; Ryan Chiu, University of Illinois College of Medicine; Orly Farber, Stanford University School of Medicine

Subject: National Guidelines for Guardianship

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Guardianship is defined as a legal relationship created when a state court grants a person or entity the authority to make decisions on behalf of an incapacitated individual concerning his/her person or property[1,2], and

Whereas, Incapacity is defined as the inability "to meet essential requirement for physical health, safety, and self-care even with appropriate technological assistance" (functional incapacity) or the inability to "receive and evaluate information or make or communicate decisions" (cognitive incapacity)[3,4], and

Whereas, A guardian is expected to direct an individual's assets and benefits towards "food, clothing, housing, medical care, personal items, and other immediate and reasonably foreseeable needs"[2], and

Whereas, Approximately 1.5 million adults in the U.S. are under the care of guardians[5–7], and

Whereas, The U.S. Census Bureau estimated within the U.S. there were over 46 million individuals aged 65 and older (2014) and that figure would double by year 2050[1], and

Whereas, Given the anticipated growth of the geriatric population and the prevalence of neurodegenerative diseases, more comprehensive guardianship programs and standard state-level guidelines are warranted to ensure continued delivery of quality care[8,9], and

Whereas, Guardianship programs are overseen by individual states' laws, regulations, and court systems as there is currently no nationwide system of guardianship in place[1,2,10–13], and

Whereas, In September 2016, only 12 states required certification of professional guardians who may come from family, friends, corporate professionals, or government officials, and in many states, guardians are not required to receive any formal training[6,14], and

Whereas, In 2011, the Government Accountability Office (GAO) determined there was widespread failure of guardians to faithfully execute their court-ordered duties including through neglect, abuse, and financial exploitation, inadequate screening and training of, and insufficient oversight of guardians after appointment[2,15], and

Whereas, Oversight and evaluation of guardians is often minimal, and courts and public systems often are so underfunded and understaffed that they experience great difficulty enforcing what little regulations and protections may be in place[1,5,7,16], and

Whereas, Improper granting of guardianship deprives individuals of civil liberties including their right to self-determination, excludes them from the normal decision-making process, and contributes to further isolation and erosion of actual and self-perceived abilities[2,17,18], and

Whereas, Poor collection and management of guardianship data across state governments and court systems together with a lack of guardian registries in many states have rendered it difficult to comprehensively understand the issue and legislate appropriate responses to abuse by guardians[10,13], and

Whereas, The lack of a gold standard for evaluating indications for guardianship in the healthcare setting contributes to delays in process initiation, decreased prompt access to follow-up services, and increased number of medically unnecessary admission days and total expenses[13], and

Whereas, Current AMA and AMA-MSS policy do not address the disparities in guardianship laws that have enabled numerous cases of abuse and left vulnerable those they are meant to protect, therefore be it

RESOLVED, That our AMA collaborate with relevant stakeholders to encourage development of an evidence-based gold standard for assessing an individual's capacity and need for guardianship, and for periodically re-assessing indications for continued guardianship, and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to advocate for federal creation and/or adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures including but not limited to protocols for providing guardians and/or guardian candidates with training, certification, registration, and continuing education within their states of operations.

Fiscal Note: Significant, 12

Date Received: 09/23/2018

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Relevant AMA and AMA-MSS Policy

Elder Mistreatment D-515.985

Our AMA:
1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.
2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.
3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education,

specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.
4. Encourages substantially more research in the area of elder mistreatment.
5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.
6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous objective measurements so that interventions and outcomes of treatment can be evaluated.
7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation.

Elder Mistreatment H-515.961

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness.

Health Care Costs of Violence and Abuse Across the Lifespan D-515.984

1. Our AMA urges the National Academies of Sciences, Engineering, and Medicine to continue to study the impact and health care costs of violence and abuse across the lifespan.

2. Our AMA 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.

3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.

Family and Intimate Partner Violence H-515.965

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

2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing

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

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

4. Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

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

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

Education of Medical Students About Domestic Violence Histories 295.079MSS

AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk.

Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.

To protect patients’ well-being, physicians individually should:

(a) Become familiar with:

How to detect violence or abuse, including cultural variations in response to abuse
Community and health resources available to abused or vulnerable persons
Public health measures that are effective in preventing violence and abuse
Legal requirements for reporting violence or abuse
(b) Consider abuse as a possible factor in the presentation of medical complaints.

(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.

(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in “normal” families, is a private matter best resolved without outside interference, or is caused by victims’ own actions.

(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.

(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.

(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:

Inform patients about requirements to report.
Obtain the patient’s informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient’s refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.

Collectively, physicians should:

(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.

(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.

(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution 56
(I-18)

Introduced by: Priyanka Gaur, UT Southwestern Medical Center; Neel R. Nabar, Sidney Kimmel Medical College at Thomas Jefferson University; Baillie Bronner, University of New Mexico School of Medicine

Subject: Support for Patient-Centered EHRs

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Patients with access to their medical records are better able to monitor chronic conditions, adhere to treatments, and track progress in disease management programs;[1] and

Whereas, Physicians who use patient engagement tools are able to achieve better health outcomes because patients are informed and prepared for clinical encounters;[2,3,4,5] and

Whereas, 5% of patients who access their online medical records transmit their health data to an application, 25% contribute information to their records, and the majority view test results, perform health-related tasks, and communicate with providers;[6] and

Whereas, 1 in 10 patients with access to their medical records identify errors in their health records and bring these to the attention of their providers;[7] and

Whereas, Patients who access their online records more than three times a year report greater trust (84% versus 69%) that their providers will protect their privacy rights;[8] and

Whereas, Patients with access to their health records express >10% greater satisfaction with their care, and 8 in 10 individuals report their charts are easy to understand and useful;[9,10,11] and

Whereas, The Office of the National Coordinator for Health Information Technology launched objectives for physicians to engage patients in their health care using EHR technology, and the 21st Century Cures Act includes provisions to improve patients' access to their electronic health information;[12,13,14] and

Whereas, Patient engagement health information technology tools are online platforms that give patients access to their health information, and most prominently include patient portals followed by personal health records (PHRs) and application programming interfaces (APIs);[15] and

Whereas, Only 52% of patients report having online access to their medical records, and formal record requests often take weeks to process;[16,17] and

Whereas, Not all practices have implemented online platforms for sharing health information with patients, and many convenience features like the ability to view, download, and transmit health information do not function well in online medical records;[18] and

Whereas, Patients who are encouraged by health care providers to use their online medical record are nearly two times more likely to access it, and 25% of individuals with access to an online medical record did not view their record in 2017, suggesting that patients may not be aware of the full potential of online medical records;[19,20] and

Whereas, Physicians who embrace patient engagement tools have higher satisfaction because these tools enhance the patient-provider relationship, improve patient adherence, and lessen the administrative burden;[21,22,23,24,25] and

Whereas, Most physicians acknowledge an evolution towards open medical records, including physician note sharing, and this approach has been employed in Sweden and is the norm in many resource-limited countries in Sub-Saharan Africa and South America;[26,27] and

Whereas, OpenNotes is a decade-old movement implemented in over 120 healthcare systems urging health care providers to allow patients access to notes they write during a visit, but notes remain the least frequently type of reported information in online medical records (51%);[28,29] and

Whereas, One potential barrier to shared notes is a cultural one, as providers are concerned about confusing patients with medical jargon and offending patients with note content, but opt-out functionality provides a workable solution and is built into most patient portals;[30,31] and

Whereas, Beth Israel Deaconess Medical Center, a pilot site for OpenNotes, reports little to no impact on physician workflow with note sharing in addition to improvements in health care quality and patient safety attributed to fuller patient engagement;[32,33,34] and

Whereas, H-315.971 sets guidelines for patient access to physicians' electronic medical systems, and D-478.979 advocates for the study and integration of hospital EHRs with Internet-based PHRs, policy is lacking on meaningful patient engagement via all accessible online platforms, including patient portals, PHRs, APIs, and various eHealth tools; therefore be it

RESOLVED, That our AMA support patients' digital access to their health records; and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to ensure physician education on best practices for sharing patients' health information via online platforms; and be it further

RESOLVED, That our AMA encourage the Centers for Medicare & Medicaid Services (CMS) to study the information needs of patients to better design systems enabling patient access to their medical records and leverage health information technology as a patient engagement tool; and be it further

RESOLVED, That our AMA study the benefits and drawbacks of open note sharing as a method to improve patient health data accessibility.

Fiscal Note: Significant, 12

Date Received: 09/26/2018

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RELEVANT AMA AND AMA-MSS POLICY

Patient Information in the Electronic Medical Record H-315.971

AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

1. Online interactions are best conducted over a secure network, with provisions for privacy and security, including encryption.

2. Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known. (c) Keep a written record, electronic or paper, of each patient authenticated. (3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

3. If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

4. Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.

5. Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.

6. In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

7. Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.

Promoting Internet-Based Electronic Health Records and Personal Health Records D-478.979
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.

Promoting Internet-Based Electronic Health Records and Personal Health Records 160.016MSS
AMA-MSS will ask the AMA to (1) advocate for the integration of provider and hospital electronic health records (EHRs) with Internet-based personal health records (PHRs) as an option for patients; and (2) advocate as a priority for all Internet-based PHRs to be fully HIPAA- compliant. (MSS Res 15, A10) (AMA Res 809, I-10 Referred) (Reaffirmed: MSS GC Rep A, I-14)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 57
(I-18)

Introduced by: Region 4

Subject: Promoting the Implementation of and Education Regarding Teleneurology along the Stroke Belt and other Rural Patient Populations

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The CDC reported in 2017 that cerebrovascular accidents to be the 4th leading cause of death in the United States;[12] and

Whereas, the CDC also delineated that the economic burden of stroke due to healthcare expenses, medicines, and lost productivity is $34 million[1] and,

Whereas, in the general US, 87% of those living in major cities live within 60 minutes travel to a primary stroke center, 9% of those living in the suburbs, and only 1% living in rural areas had such access;[4] and,

Whereas, the Southeastern United States and Mississippi Valley Region encompass “The Stroke Belt” with some of the highest rates of stroke morbidity and mortality[1] with the incidence of stroke 10% or more greater than the national average;[8] and,

Whereas, 31.5% of patients living in a stroke-belt county with high-stroke mortality had 60-minute access to a primary stroke center (PSC) compared to 50.7% of patients living in a stroke-belt county with low stroke mortality

Whereas, the rural-urban geographic disparity in the use of life-saving tissue plasminogen activator (tPA)[3] is increasing, where it is presumed hospitals without timely access to stroke expertise underuse this effective stroke therapy;[11] and,

Whereas, stroke telemedicine (telestroke) is a novel modality used to facilitate the care of patients with acute stroke;[11] and,

Whereas, outcomes between patients directly admitted to a stroke center compared to that of patients with remote supervision of intravenous tPA initiation and subsequent transport to a PSC are similar;[2] and,

Whereas, telemedicine utilized for rural Native American communities has positively impacted the cost, quality, and access to healthcare in these areas;[7] and,

Whereas, according to a survey done by the Robert Graham Center, 88.9% of physicians that utilize telemedicine and 76.8% that do not, say that telemedicine improves access to healthcare;[10] and,

Whereas, teleneurology has been utilized increasingly in the US over the past decade and has resulted in decreased mortality and better lifestyles following stroke;[13] and,

Whereas, organized telestroke units implemented in rural Germany showed that the implementation of telemedicine in treatment of acute stroke reduced the probability of a poor outcome by 62%, with 44% of patients treated in telestroke hospital had a poor outcome after three months compared to 54% of patients in facilities without organized telestroke units;[1] and,

Whereas, existing AMA policy supports “comprehensive stroke legislation … to help improve our nation's system of prevention and care.” (H-425.978), and

Whereas, existing AMA policy supports “continued and intensified efforts to develop and implement proposals for improving rural health care.” (H-465.994), and

Whereas, additional existing AMA policy acknowledges the evolving impact of telemedicine and supports appropriate practices of telemedicine provided that evidence-based analysis exists that examine the “costs, quality, and the physician-patient relationship” established through telemedicine (H-480.974); therefore be it

RESOLVED, That our AMA-MSS encourage the use of tele-stroke medicine for communities along areas of high stroke incidence such as states along the Stroke Belt and other rural populations with similar healthcare disparities, to target the burden of stroke in these populations; and be it further

RESOLVED, That our AMA-MSS encourage the application of tele-neurology and tele-stroke into medical school curriculum to provide future generations of physicians, especially those serving rural populations, a reliable tool in battling neurological and stroke cases; and be it further

RESOLVED, That our AMA-MSS reaffirm existing AMA-MSS policy D-295.313.

Fiscal Note: Moderate, 9

Date of Submission: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

Stroke Prevention and Care Legislation H-425.978

1. Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of prevention and care.

Evolving Impact of Telemedicine H-480.974

1. 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.

Improving Rural Health Care H-465.994

1. The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 58
(I-18)

Introduced by: Nicholas Benson, Maneesh Tiwari, and Bradley Pearson, University of Cincinnati College of Medicine; Julie Lin and Harshitha Dudipala, Northeast Ohio Medical University; Shiri Nawrocki, Rutgers University Robert Wood Johnson Medical School; Neel Nabar, Sidney Kimmel Medical College at Thomas Jefferson University

Subject: Addressing Medical Data Vulnerabilities in Bluetooth and Other Short-Range Wireless Technologies

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Medical devices which send and receive data wirelessly, relying on Bluetooth (BT) and radio frequency (RF) technology, are becoming increasingly sophisticated and common in healthcare;[1] and

Whereas, Manufacturers are incorporating BT and RF technology into pacemakers, defibrillators, insulin pumps, and neuro-stimulators despite well-documented security flaws, including the ability to forcefully access and wirelessly reprogram these devices;[2-4] and

Whereas, The Department of Homeland Security (DHS) has issued multiple national security bulletins detailing the threat posed to medical data infrastructure by devices capable of remote connection;[5-7] and

Whereas**,** In March 2018, a report filed to the DHS revealed a lack of basic information-security measures in the use of many GE medical devices, including changing factory-set authorization credentials;[8]

Whereas, In August 2017, the FDA issued its first recall of an implantable medical device, citing data vulnerabilities in RF-enabled cardiac pacemakers;[9] and

Whereas, Existing AMA policy calls for our AMA to “support the use of mobile health applications… and associated devices, trackers and sensors by patients, physicians and other providers” (H-480.943); therefore be it

RESOLVED, That our AMA study the degree of medical data vulnerability due to compromised Bluetooth and radio frequency technology in medical devices, and be it further

RESOLVED, That our AMA encourage industry and regulatory partners to develop and implement standards for the safe use of Bluetooth and radio frequency technology by manufacturers, healthcare professionals, and patients.

Fiscal note: Significant, 10

Date received: 09/23/18

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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.

Integration of Mobile Health Applications and Devices into Practice H-480.943
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical

practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

Information Technology Standards and Costs D-478.996

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

Electronic Data Interchange Status Report H-315.979

Our AMA will: (1) work to establish consensus on industry security guidelines for electronic storage and transmission of medical records as an important means of protecting patient privacy in a manner that avoids undue and non-productive burdens on physician practices; and (2) develop relevant educational tools or models in accordance with industry electronic security guidelines to assist physicians in compliance with state and federal regulations.

Improving Cybersecurity in Healthcare Facilities 315.006MSS

AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 59
(I-18)

Introduced by: Student National Medical Association; Sophia Spadafore, University of Arizona College of Medicine – Tucson; Sarah Mae Smith, University of California, Irvine, School of Medicine; Omar Salman, Virginia Tech Carilion School of Medicine; Ellena Popova, University of Pennsylvania Perelman School of Medicine; Samuel Dubin, New York University School of Medicine

Subject: Removing Sex Designation from the Birth Certificate

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Our AMA believes that the physician's nonjudgmental recognition of patients' gender identities enhances the ability to render optimal patient care (H-160.991); and

Whereas, The legal sex designated on a birth certificate by a physician is typically based solely on an external evaluation,[1] and does not always reflect the child’s chromosomal or hormonal status; and

Whereas, Up to 2% of live births in Northern America deviate in some way from binary designation as male or female sex identification,[2] and are therefore categorized incorrectly on their birth certificate; and

Whereas, The gender identity of a person does not necessarily correlate with their sex assigned at birth, and gender identity and expression can be fluid over time, therefore causing discordance with a person’s legal sex designation;[1,3] and

Whereas, The certificate of live birth reported to the state draws on the information contained in the family's medical records but is a separate document,[4] therefore, the information in the birth certificate is used only for public health statistics and legal functions, and is not used for patient care or any medically related purpose;[5,6] and

Whereas, Birth certificates were originally intended to serve as records of the existence and circumstances of birth but are currently widely used in determining eligibility for employment, obtaining other identification documents (driver’s licenses, passports, Social Security cards), proving age, and enrolling in government programs;[5] and

Whereas, Our AMA supports the right of transgender and gender non-conforming individuals to change the sex on their birth certificate to reflect their gender (H-65.967); and

Whereas, In 2017, California passed the Gender Recognition Act, and in 2018 New York City passed a bill allowing residents to opt for a third, non-binary gender category on birth certificates and alleviating barriers to changing sex designation on birth certificates;[7,8] and

Whereas, The cost of changing the sex designation on a birth certificate can range from $10 to $310 depending upon the state one resides in,[9,10] and 32% of transgender people with an ID who wanted to change the sex did not do so due to cost;[11] and

Whereas, Only 9% of transgender people who want to change the sex designation on their birth certificate actually do so;[11] and

Whereas, The process of changing sex designation on a birth certificate is complex and typically requires legal counsel, adding additional cost and a necessary education level that further disenfranchises the most vulnerable of transgender and intersex people;[11] and

Whereas, Interfacing with bureaucracy and administrative processes that only acknowledge binary gender and require confirmatory paperwork exposes transgender and intersex people to an inherently discriminatory system and makes them vulnerable when navigating such a system;[10] and

Whereas, The World Professional Association for Transgender Health (WPATH) states that "no person should have to undergo surgery or accept sterilization as a condition of identity recognition,"[12] and the American Psychological Association (APA) has stated the basis for changing gender markers on identity documents is a person's "social transition" rather than a specific medical event such as hormones or surgery;[13] and

Whereas, Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on sex and new state-level policies allow birth certificate sex designation to be changed with the endorsement of a medical provider on the basis of gender identity, not anatomy;[11] and

Whereas, Almost every state requires a gender affirmation surgeon to provide a letter supporting an individual's request for a legal sex designation change on their birth certificate,[14] while less than 4% of transgender men and 23% of transgender women choose to pursue surgical transition;[10] and

Whereas, The National Transgender Discrimination Survey found 24% of transgender people were able to correct the gender marker on their birth certificates, 18% were denied the correction, and 53% had not attempted correction, and also showed that individuals who had not pursued surgical transition were six times less likely to pursue birth certificate correction compared to those who surgically transitioned;[11] and

Whereas, A national survey of transgender individuals showed 40% of transgender people were harassed due to presenting identification that does not match their gender presentation, 15% were asked to leave an establishment, and 3% were assaulted;[10] and

Whereas, The legal sex designated on birth certificates has been used in North Carolina to force transgender adults to use the public restroom aligned with their birth certificate, causing emotional distress and physical violence, and similar policies have been introduced in 16 other states;[15] and

Whereas, The legal sex designated on the birth certificate has been used in North Carolina to limit transgender students' rights in schools, with similar policies introduced in 14 other states;[9] and

Whereas, The U.S. Federal Bureau of Prisons released revisions to its Transgender Offender Manual in May instructing the Transgender Executive Council (TEC) to "use biological sex as the initial determination for designation" in determining the facility assignments for transgender and intersex prisoners and stating that "the designation to a facility of the inmate's identified gender would be appropriate only in rare cases… where there has been significant progress towards transition as demonstrated by medical and mental health history," removing language that directed the TEC to "recommend housing by gender identity when appropriate";[16,17] and

Whereas, The lived sex or gender identity of a person can be self-reported and would satisfy public health needs for tracking population statistics;[18] and

Whereas, It has been proposed that removing "sex" from the birth certificate and allowing individuals to self-report gender allows for fluidity in gender identity and removes the barriers of changing legal documents;[19] therefore be it

RESOLVED, That our AMA support legislation to remove "sex" as a legal designation on the birth certificate; and be it further

RESOLVED, That our AMA create model state legislation to remove "sex" as a legal designation on the birth certificate and allow self-designation of gender on legal documents.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

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.

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961
Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.

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.

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.

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients 65.019MSS
AMA-MSS supports (1) policies that reduce barriers to and allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a health care provider that the individual is undergoing or has undergone gender transition according to applicable medical standards of care; and (2) that sex designation on an individual's birth certificate, or any change thereof, not hinder access to appropriate medical care. (MSS Res 12, I-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 60
(I-18)

Introduced by: Region 3, Region 7; Meera Kapadia, University of Arizona College of Medicine - Tucson

Subject: Enhancing Education and Reducing Advertising of Alcoholic Beverages

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The primary causes of fatal and non-fatal injuries in adolescents are motor vehicle accidents, homicides, violence, and suicides with an underlying correlation with alcohol consumption;[1,2] and

Whereas, 1,825 college students between the ages of 18 and 24 die annually from alcohol-related unintentional injuries, including motor-vehicle crashes;[2,19] and

Whereas, 58.0% of full-time college students ages 18–20 illegally drank alcohol and 22.5% of them reported heavy alcohol use (>5 drinks per day) in the past month;[3] and

Whereas, People aged 12 to 20 years of age drink 11% of all alcohol consumed in the U.S. every year, more than 90% of this amount is consumed in the form of binge drinking;[7] and

Whereas, About 1 in 4 college students report academic consequences from drinking alcohol, including missing class, falling behind in class, doing poorly on exams or papers, and receiving a lower GPA;[2] and

Whereas, Alcohol consumption reduces self-control and increases risky behaviors such as unsafe sex or dangerous driving due to affecting the pre-frontal cortex, and is associated with a decreased life expectancy;[4] and

Whereas, Animal studies suggest that alcohol may have a greater impact on adolescent than adult memory and cognition, and that these effects are long-lasting;[5,6] and

Whereas, Death due to alcohol-related liver disease, including cirrhosis and hepatocellular carcinoma, has increased by 65% since 1999, especially in people 25-36 years of age;[8] and

Whereas, Youth who start drinking before age 15 are six times more likely to develop alcohol dependence or abuse later in life than those who begin drinking at or after age 21 years;[2] and

Whereas, According to the NIH, 88,000 people die of alcohol-related causes every year, making it the third most common preventable cause of death in the U.S. after tobacco and poor diet and lack of exercise;[9,10] and

Whereas, The CDC recommends decreasing the exposure of underage persons to alcohol advertisement as a means for decreasing underage drinking;[7] and

Whereas, The American Society of Clinical Oncology supports the promotion of public education about the risks between alcohol abuse associated with certain types of cancer;[11] and

Whereas, One of the suggested methods for decreasing the prevalence of underage drinking is reducing commercial and social availability of alcohol;[12] and

Whereas, The United Nation's Sustainable Development Goal (SDG 3) hopes to Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol by 2030;[13] and

Whereas, Alcoholic beverage brands popular among underage drinkers target this age group by advertising in magazines with underage readership 8 times more than other alcoholic beverage brands;[14] and

Whereas, Males aged 18-20 were found in a study to be the target group for magazine advertisements by 11 of the 25 most popular alcohol brands for that group and were within 10% of the most heavily targeted age group by another 6 of those brands;[15] and

Whereas, Females aged 18-20 in that same study were the target group for magazine advertisements by 16 of the top 25 brands consumed by that group, and were within 10% of the target group for another 2 brands;[15] and

Whereas, The alcoholic beverage industry is allowed to self-regulate its advertisements while regulatory agencies like the Federal Trade Commission (FTC) report on trends in alcoholic beverage marketing;[16] and

Whereas, Studies have shown that 7-9% of alcoholic beverage advertisements are in violation of the industry's self-imposed requirement of no more than 30% of the audience of that ad being under the age of 21;[17,18] and

Whereas, 32% of all alcohol advertising occurred when more youth were watching TV than those over 21 years old, and 14.6% of the audience of all alcohol advertisements in the most recent report by the FTC was under the age of 21;[17,18], therefore be it

RESOLVED, That our AMA supports legislation imposing age limits on alcohol advertising and providing appropriate agencies the authority to enforce this legislation; and be it further

RESOLVED, That AMA policy H-30.940 section (3b) be amended so it reads as follows:

> AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages
> H-30.940
> (3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television and other public media such as billboards, magazines, and social media to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all

mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.; and be it further

RESOLVED, That our AMA reaffirms policies H-60.928 and D-60.973.

Fiscal note: Minimal, 6

Date received: 9/23/18

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RELEVANT AMA AND AMA-MSS POLICIES:

AMA policy H-60.928

Our AMA encourages advertising associations to work with public and private sector organizations concerned with child and adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image.

AMA policy 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.

AMA policy H-60.941

Our AMA encourages increased medical and policy research on the harmful effects of alcohol on adolescents and young adults and on the design and implementation of environmental strategies to reduce youth access to, and high consumption of, alcohol.

AMA policy H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

AMA policy H-170.992

Our AMA: (1) supports continued encouragement for increased educational programs relating to use and abuse of alcohol, marijuana and controlled substances; (2) supports the implementation of alcohol and marijuana education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol.

AMA policy H-30.940

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.

(2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may

encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); and (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).

(3.) Actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.

(4.) (a) Urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 61
(I-18)

Introduced by: Haritha Pavuluri and Tristan Mackey, University of South Carolina School of Medicine Greenville, SC

Subject: Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, [1] Approximately 1.4 million individuals in the United States identify as transgender, and

Whereas, [2] 2.4 million individuals over the age of 50 identify as members of the LGBT community, a number that is predicted to double by 2030, and

Whereas, [3] 39% of transgender individuals reported experiencing serious psychological distress and 40% reported having attempted suicide in their lifetime, and

Whereas, [4] 28% of transgender individuals reported postponing needed medical care due to fear of discrimination, which contribute to the significant health disparities they experience, and

Whereas, [3] 33% of transgender individuals in a survey identified having at least one negative experience with their healthcare provider in the last year, and

Whereas, [5] Only 49.5% of transgender men have had a Pap smear screening within the past 3 years and 31.9% of transgender men have never had Pap smear screening, and

Whereas, [5] A majority of transgender men prefer self-sampling to screen for cervical cancer versus provider-administered Pap smear, and

Whereas, [6] Individuals in a study who classified their gender expression as “female” were significantly more likely to have routine Pap testing compared with individuals who identified as “transgender,” and

Whereas, [7] Transgender individuals may often require specific screenings and considerations, particularly if they have past or current usage of hormone therapy, such as monitoring for diabetes mellitus in Transgender women, as they have an increased risk for development of diabetes mellitus while on estrogen therapy, and

Whereas, [7] In a transgender woman with an intact prostate, it is recommended to regularly screen for prostate cancer, and

Whereas, [8,9] The US General Accountability Office’s Health Information Technology (HIT) Policy Committee recommended the inclusion of gender ID data in electronic medical records (EMR)

and recent research demonstrates current proposed Systematized Nomenclature in Medicine (SNOMED) codes do not reflect these recommendations, and

Whereas, [10] the World Professional Association for Transgender Health (WPATH) executive committee in 2011 recommended demographic variables in EMR include assigned sex at birth, gender identity, and pronoun preference, but these practices remain uncommon in the United States, and

Whereas, [11] In a study to determine the extent to which patients' notes in EMR contained transgender-related terms that corroborated ICD-coded (International Classification of Diseases) transgender identity, 89.3% of patients defined as transgender were identified with transgender-related terms, and

Whereas, [12] Research shows misgendering and misclassification are psychologically disruptive and are associated with negative affect, negative impact on mental health, and transgender-felt stigma, and

Whereas, The above data indicates that EMR can have a negative impact on the mental health of transgender individuals due to misgendering from EMR that is not fully inclusive of transgender patients, and

Whereas, [7] Pap smears may be traumatic for transgender patients with no history of sexual activity involving vaginal penetration, and EMR indicating transgender identity and related history can allow the physician and healthcare team to properly care for the individual during a pap smear, and

Whereas, Based on data stated above, discrepancies in EMR system may contribute to poor health outcomes in transgender individuals.

Whereas, our AMA believes that the physician's recognition of patients' sexual orientations, sexual behaviors, and gender identities without judgement or bias optimizes patient care in health as well as in illness, and that this recognition is especially important in addressing the specific health care needs of people who are or may be LGBTQ (AMA policy H.160.991); therefore, be it

RESOLVED, That our AMA advocate for legislation to support the inclusiveness of transgender patients within medical record systems and patient portal systems to include and accommodate their unique healthcare needs; and be it further

RESOLVED, That our AMA amend AMA Policy H-160.991 to include AMA support for inclusion of LGBTQ specific health needs into EMRs.

Fiscal note: Significant, 12

Date received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer 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, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ 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 LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ 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 sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy 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; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ 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 LGBTQ people.

H-65.967 Conforming birth certificate policies to current medical standards for transgender patients

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.

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)

65.017MSS Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers

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) (Reaffirmed: MSS GC Rep A, I-16)

295.191MSS Education Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients

AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

> Healthcare Needs of Lesbian Gay Bisexual and Transgender Populations H160.991
> Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and female-to-male transgender patients when medically indicated 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 of sexually transmitted diseases. (MSS Res 14, A-17)

310.041MSS Improving Primary Care Residency Training to Advance Health Care for Gay, Lesbian, Bisexual, and Transgender Patient

AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for gay, lesbian, bisexual, and transgender (GLBT) pediatric patients. (MSS Res 11, A-10) (AMA policy H-295.878 Amended in Lieu of AMA Res 906, I-10) (Reaffirmed, MSS GC Rep D, I-15)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 62
(I-18)

Introduced by: Region 4

Subject: Advocating for Physician Involvement in FDA User Fee Agreements

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The Food and Drug Administration (FDA) developed User Fee Agreement programs in 1992 as a way for pharmaceutical and medical device companies to expedite the approval process of their products[1]; and

Whereas, Through User Fee Agreements, the FDA sets specific fees for pharmaceutical and medical device companies to pay upon application[1,2]; and

Whereas, The FDA uses these fees to increase the efficiency of regulatory processes with a goal of reducing the time it takes to bring these products to the U.S. market[1,2]; and

Whereas, In the recent User Fee Agreement negotiation, the FDA and industry stakeholders introduced major public policy which excludes physician input and prioritizes the interests of said industry stakeholder[3]; and

Whereas, The Medical Device User Fee Amendments (MDUFA) Draft Agreement IV negotiated in 2016 introduced new FDA policy regarding alternative oversight models, specifically Software as a Medical Device (SaMD), as one example[3]; and

Whereas, The original intention of User Fee Agreements was to streamline efforts to bring pharmaceuticals and medical devices to the U.S. market, with the introduction of negotiating policy related to regulation and oversight between the FDA and industry stakeholders considered a novel component of User Fee Agreements that physician organizations should be allowed to actively participate in; therefore be it

RESOLVED, That our AMA advocate that physician organizations have a role in FDA User Fee Agreements, particularly those that introduce points of policy.

Fiscal note: Significant, 12

Date received: 09/23/18

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1. FDA User Fee Programs. U.S. Food and Drug Administration.
2. Brennan, Z. Regulatory Explainer: FDA User Fee Reauthorizations From 2018 to 2022. *Regulatory Affairs Professional Society.* August 21, 2017.
3. MDUFA Performance Goals and Procedures, Fiscal Years 2018-2022. U.S. Food and Drug Administration. December 2, 2016.

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
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.

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.
CSAPH Rep. 8, A-10; Reaffirmed: Res. 917, I-10; Appended: CSAPH Rep. 3, I-12

Medical Device Amendments of the FDA H-480.996
1. The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.
Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10

Medical Device Safety and Physician Responsibility H-480.972
1. The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use.
Res. 507, I-95; Res. 509, A-96; Appended Res. 504, A-99; Reaffirmed: CSAPH Rep. 1, A-09

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 63
(I-18)

Introduced by: Region 5

Subject: Protect People Who Use Drugs from Prosecution in the Event of Overdose

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, In 2016 drug overdoses killed 63,632 Americans, and recent estimates suggest that overdoses kill 200 people per day in the USA;[1,2] and

Whereas, Drug overdose is the leading cause of preventable death in the USA; in 2014, deaths from opioid overdoses have surpassed deaths from motor vehicle accidents;[3] and

Whereas, Opioid overdose can be effectively reversed using the opioid antagonist naloxone, but only if this antidote is provided before overdose symptoms lead to death;[4,5] and

Whereas, Between 21-68% of overdose bystanders call 911, and many delay calling or refrain from calling 911 altogether;[6] and

Whereas, Fear of arrest is cited as major deterrent to calling 911 during overdose;[6,7] and

Whereas, A drug-induced homicide is defined as a crime in which a person delivered or provided drugs to another person that resulted in their death;[8,9] and

Whereas, One of the primary reasons that these laws began to take place was due to the death of Len Bias, a college basketball star who died due to a cocaine overdose and his friend who had called 911 was accused of providing the cocaine; following his death states began to pass Len Bias or “drug delivery resulting in death” laws;[10] and

Whereas, 40 states have passed some form of a “Good Samaritan Law” (GSL) as endorsed by our AMA (D-95.977) to provide people who seek medical assistance in the event of an overdose with limited immunity from drug-related offenses;[11] and

Whereas, GSLs provide variable legal protection by state, which may confer protection against prosecution for: the possession of illicit/controlled substances, paraphernalia, and parole/pretrial/probation violations;[6] and

Whereas, GSL do not protect against prosecution for drug-induced homicide, with some states even having explicit drug-induced homicide laws;[12,13] and

Whereas, Only Vermont and Delaware provide immunity for drug-induced homicide if a person seeks medical assistance;[12] and

Whereas, Drug-induced homicide laws were originally intended to prosecute high level drug dealers, yet an individual may be prosecuted even without selling drugs to the victim;[9] and

Whereas, The amount of prosecutions for accidental overdose deaths has more than doubled between 2015 and 2017 with over 1000 arrest over those years;[14] and

Whereas, Family members, friends, and partners are the frequent victims of prosecutions and convictions in relation to accidental overdose deaths;[14,15,16] and

Whereas, The number of prosecutions of drug-induced homicide have increased over 300% since 2011, with the Midwest accounting for a large portion of this increase;[12] and

Whereas, Increases in drug-induced homicide prosecutions are correlated with increases in fatal overdose rates;[12] therefore be it

RESOLVED, That our AMA oppose the use of drug-induced homicide laws and other manslaughter and felony murder laws to prosecute individuals who were in the presence of a person who died due to drug use; and be it further

RESOLVED, That our AMA work with state and local medical societies to advocate for the expansion of Good Samaritan Laws to include all people present at the time of the overdose and to provide immunity for all types of drug related prosecution

Fiscal note: Significant, 10

Date received: 09/23/18

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8. US Food and Drug Administration. Drug Abuse and Prevention Act Subchapter 1 – Control and Enforcement. Accessed September 24, 2018. https://www.gpo.gov/fdsys/pkg/USCODE-2017-title21/html/USCODE-2017-title21-chap13-subchapI-partD-sec841.htm
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RELEVANT AMA AND AMA-MSS POLICY:

911 Good Samaritan Laws D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.

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.

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.

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.
8. Our AMA urges the Food and Drug Administration to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

Promoting Prevention of Fatal Opioid Overdose MSS100.010
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the education of health care workers and opioid users about the use 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)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 64
(I-18)

Introduced by:	Region 2; Region 3; Nicholas Benson, University of Cincinnati College of Medicine
Subject:	Augmented Intelligence and Physician Data Science Literacy
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Data science is an approach to statistical analysis that utilizes information technology, computer science, and artificial intelligence;[1-2] and

Whereas, Artificial intelligence constitutes a host of computational methods that produce systems that perform tasks normally requiring human intelligence, such as machine learning and natural language processing, and are used to improve predictive analyses;[3-6] and

Whereas, Augmented intelligence, the healthcare-appropriate term for artificial intelligence favored by the AMA, reflects the enhanced capabilities of human clinical decision-making when coupled with advanced computational methods and systems; and

Whereas, Augmented intelligence is rapidly being used as a routine part of clinical care, in areas ranging from subspecialties to primary care;[6-14] and

Whereas, Experts have raised significant ethical and procedural concerns regarding proper implementation of augmented intelligence in healthcare settings, particularly regarding the introduction of a third party into the physician-patient relationship and the codification of existing biases;[4,14-18] and

Whereas, Data science literacy is essential to the effective implementation of augmented intelligence in the healthcare setting, including the critical interpretation of conclusions and analysis of publications that rely on this technology;[18-22] and

Whereas, Few medical education programs provide robust data science curricula;[23-25] and

Whereas, Industry leaders have identified a critical need to implement data science education in medical schools and hospitals;[26-29] and

Whereas, Existing AMA policy states that the AMA will encourage education for patients, physicians, medical students, health administrators, and other healthcare professionals to promote greater understanding of the promise and limitations of healthcare augmented intelligence;[30] and

Whereas, The rise of augmented intelligence in healthcare signals the need for standardized, core competency guidelines for physician data science literacy;[31] therefore be it

RESOLVED, That our AMA develop core physician data science competency guidelines.

Fiscal note: Significant, 12

Date received: 09/24/18

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RELEVANT AMA AND AMA-MSS POLICY:

Clinical Algorithm Impact on Patient Care H-410.971
The AMA has established the following policy that incorporates provisions regarding the use and development of clinical algorithms, which may include the following: (1) Clinical algorithms are guidelines established to aid a physician in the diagnosis and treatment of patients. As such, they should be used by the physicians as guidelines, but recognizing that each patient is an individual and has unique needs and problems, the physician should use his or her best judgment in the use of the guidelines and should never be forced to specifically follow these guidelines rigidly. (2) Clinical algorithms should include suggested tests and procedures to arrive at a correct diagnosis in the most direct and expeditious manner. These guidelines should suggest criteria as to when referrals to the correct specialist/subspecialist are appropriate and in the best interest of the patient. (3) The treating physicians should always have the option of ordering the suggested tests, procedures and referrals at their discretion, and may opt to make these choices earlier or later than is suggested, and is not mandated to make any of these choices, depending on their clinical assessment of the patient and their needs. (4) When the algorithms are created, physicians from the specialty(ies)/subspecialty(ies) who diagnose and treat the condition should participate in their creation. These physicians should be representatives from their official specialty society(ies). (5) The validity of any clinical algorithms should be under constant review and evaluation by the appropriate specialty/subspecialty society(ies). (6) Whenever possible consensus clinical data from peer review journals will be used.

National Agency for Technology Evaluations H-480.954
Our AMA advocates for active AMA input into any national agency whose role would be to evaluate technology for its value, to assist Medicare and other payers in making appropriate coverage decisions.

Technology and the Practice of Medicine G-615.035
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.

Modernization of Medical Education Assessment and Medical School Accreditation: AMA-MSS will ask the AMA to: (1) vigorously work to establish medical education system reforms throughout the medical education continuum that demand evidence-based teaching methods that positively impact patient safety or quality of patient care; and (2) work with the Liaison Committee on Medical Education (LCME) to perform frequent and extensive educational outcomes assessment of specialized competencies in the medical school accreditation process at minimum every four years, requiring evidence showing the degree to which educational objectives impacting patient safety or quality of patient care are or are not being attained. (MSS Res 9, A-04) (AMA Res 818, I-04 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

Medical Technology Assessment 480.001MSS
AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trails when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trails to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission, and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/ public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology.

Machine Intelligence and Data Science Literacy 480.021MSS
AMA-MSS (1) supports the development of core physician data science competency guidelines and; (2) encourages medical schools to explore the implementation of more robust data science education.

Machine Intelligence in Healthcare 485.003MSS
AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision making, including diagnosis, patient care, and health systems management; (3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; and (5) supports increased utilization of the term "machine intelligence" rather than the term "artificial intelligence" when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making.

Augmented Intelligence in Health Care H-480.940
Our AMA encourages education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 65
(I-18)

Introduced by: Region 2; Student National Medical Association

Subject: Support for Requiring Investigations into Deaths of Children in Foster Care

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, Around 670,000 children in the U.S will spend some time in foster care in any given year,[1,2,3] and the number of children in foster care has been increasing since 2012;[2,4] and

Whereas, Children in foster care represent one of the most vulnerable populations in the United States, given their early adverse experiences and their high likelihood of experiencing neglect, parental drug use or alcohol abuse, personal drug or alcohol use, physical and sexual abuse, lack of appropriate housing, and behavior problems, among others, and additionally given that more than half of the children in foster care are young people of color;[2] and

Whereas, A series of highly-publicized episodes of abuse, neglect, and child deaths in the for-profit foster care system[5,6] prompted the Senate Finance Committee to conduct an investigation into the privatization of foster care services, and the Committee published a report of their findings in 2017;[3] and

Whereas, The Senate Finance Committee report found that children in the foster care system die at an alarmingly high rate, averaging over 8 deaths per year over a ten-year period, but investigations were conducted in only 15% of deaths with no investigation undertaken or autopsy performed in all other deaths;[3,7] and

Whereas, This number of deaths was found to equate to a death rate 42% higher than the national death rate for children with similar health conditions and risk factors, and 70% of children who died under the privatized foster care company's charge died unexpectedly,[3,7] and deaths were often found to have occurred in cases in which children had been placed with foster parents who had a record of abuse;[3,5] and

Whereas, The report found that policies and procedures meant to monitor child welfare providers' performance and outcomes "are not always followed; exceptions are made, waivers are granted, profits are prioritized over children's well-being, and sometimes those charged with keeping children safe look the other way,"[3] and in some cases children were placed in homes with individuals convicted of kidnapping and other serious crimes, with individual who had substance abuse problems, and in the care of caretakers who had previously failed foster care placements;[3,5,6,7] and

Whereas, Other studies have shown children in foster care have higher rates of experiencing abuse,[8,9] adverse childhood events,[8,9] and death[10] compared to children in the general population; and

Whereas, AMA policy H-515.960 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"; therefore be it

RESOLVED, That our AMA advocate for legislation requiring investigations into deaths of children in the foster care system while the child is in the foster care system; and be it further

RESOLVED, That our AMA develop a protocol for investigating all deaths of children in foster care in an unbiased manner.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Addressing Healthcare Needs of Children in Foster Care H-60.910
Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Identifying and Reporting Suspected Child Abuse H-515.960
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.

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.

Importance of Autopsies H-85.954
1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.

2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.

3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program, and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.

4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.

5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.

6. Our AMA calls upon all third party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies.

7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.

8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.

440.062MSS Addressing Foster Care Healthcare Needs
AMA-MSS will ask that our AMA advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children. MSS Res 17, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 66
(I-18)

Introduced by: Latino Medical Student Association; Region 7; Jacquelyn Hoffman, University of Arizona College of Medicine - Tucson

Subject: Acknowledging disparities in health-care access among seasonal farmworkers in the United States

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The United States of America has been accepting seasonal farmworkers who are not US citizens to work through harvest seasons for over 80 years[1], and

Whereas, Recent estimates suggest there are approximately 1.5-2.5 million seasonal farmworkers living in the United States at any given time[2,3,4], and

Whereas, several studies suggest our agricultural industry would not survive without such laborers since no widely available alternatives to this labor force who are willing to work short-term, seasonal jobs exists, and[567]

Whereas, Once hired, seasonal farmworkers remain in the United States for several months without regular access to healthcare providers or clinics with only about 25% of farmworkers and their families seeing healthcare at a community health center, and[89]

Whereas, Most seasonal farmworkers (even those legally in the US) face significant barriers in accessing healthcare including lack of transportation, long working hours, lack of sick leave, language, lack of familiarity with the U.S. healthcare system[10], and

Whereas, According to a recent PubMed meta-analysis study, barriers faced specifically by undocumented farmworkers (approx. 50% of all farmworkers)[11] include (1) policy-level limitations to access and type of health care, (2) barriers due to bureaucratic obstacles including paperwork and registration systems, (3) limited and overwhelmed sources of alternative care available, (4) widespread discriminatory practices within the healthcare system itself, and (4) on an individual level, barriers due to immigrant's fear of deportation, stigma, and lack of capital (both social and financial) to obtain services[12]

Whereas, Jobs in the agriculture industry rank among the most hazardous of all industries in the United States due to high frequency of pesticide-related cancers, birth defects, rashes, vomiting, headaches, & neurological damage, occupational harm including lacerations, severed limbs,

and severe arthritis from repetitive work injury - all of which require immediate and intensive medical attention, and[12,13,14]

Whereas, seasonal farmworkers are therefore one of our nation's most vulnerable populations and deserve our protection as current & future healthcare providers[15]; therefore be it

RESOLVED, The AMA acknowledges there is a disparity in access to preventative healthcare for exposures unique to the seasonal farmworker population in the United States; and be it further

RESOLVED, The AMA will work with relevant stakeholders as opportunities arise to increase awareness of the discrimination that exists toward seasonal farmworkers to ensure better health outcomes.

Fiscal Note: Significant, 10

Date Received: 09/23/2018

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RELEVANT AMA AND AMA-MSS POLICY:

AMERICAN MEDICAL ASSOCIATION

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.

2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients

Individual Health Insurance H-165.920

Our AMA: supports "obtaining universal coverage and access to healthcare services" through healthcare voucher systems or individually owned health insurance to safeguard access to healthcare. The resolution also advocates for "employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage."

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Evaluation of DACA-Eligible Medical Students, Residents, and Physicians In Addressing Physician Shortages 295.185MSS

AMA-MSS will ask that the AMA study the issue of Deferred Action for Childhood Arrivals (DACA)-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. (MSS Late Res 4, I-14)

Steps in Advancing towards Affordable Universal Access to Health Insurance 165.007
(1) AMA-MSS recognizes the efforts of the AMA in assembling proposals for the advancement toward affordable universal access to health insurance and supports *Expanding Health Insurance: The AMA Proposal for Reform;* (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our AMA 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. (MSS Rep A, A-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Modified: MSS Res 12, A-17)

Evaluation of the Principles of Health Care Access Resolution 165.009

(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised;
(2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage;
(3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons;
(4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters;

(5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care;
(6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access;
(7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access;
(8) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access;
(9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

Covering the Uninsured as AMA's Top Priority 165.012

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 67
(I-18)

Introduced by:	Region 5; Region 6; Sarah Mae Smith, University of California-Irvine School of Medicine
Subject:	Oppose Requirements of Hormonal Treatments for Athletes
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, Differences of Sex Development (DSD), also known as intersex, are defined as congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical;[1] and

Whereas, There is little research on the incidence of DSD, but estimates range from 1 in 5,000 ambiguous genitalia to 1 in 1,500 for atypical genitalia;[2,3,4] and,

Whereas, A 2014 study supported by the International Association of Athletics Federations and the World Anti-Doping Agency found that 5 of 839 elite female athletes were diagnosed with hyperandrogenic 46 XY differences of sex development after medical examination;[5] and

Whereas, In 2011, the Women's Sports Foundation (WSF) released a position statement arguing that testing female athletes' testosterone levels would be "problematic and ill-advised," noting that widely-varying natural levels of testosterone in male athletes are not subject to the same scrutiny;[6] and

Whereas, The same WSF position statement also argued that it would be inappropriate to single out female athletes with naturally higher testosterone levels for exclusion from competition while other competitive advantages such as height, access to coaching from a young age, or upbringing in a high altitude are not restricted;[6] and

Whereas, In April 2018, the International Association of Athletics Federation (IAAF) imposed new regulations that require female athletes to maintain their blood testosterone levels below five nmol/L to compete in Restricted Events in International Competitions;[7,8] and

Whereas, The IAAF regulations were based on a study commission by the IAAF published in the British Journal of Sports Medicine to investigate evidence of elevated testosterone levels and improved athletic performance; however that study has been called into question with some experts calling for retraction;[9,10] and

Whereas, Independent researchers analyzed the data used for the above study and found that the performance data used in the study’s analysis was either anomalous or inaccurate 17% to 33% of the time;[11] and

Whereas, There are discrepancies between sports governing bodies that may conflict with each other in determining the metrics that make a person eligible for competition in a specific sex class;[11] and

Whereas, These new regulations have led to the IAAF requesting that female athletes with naturally high testosterone levels undergo medically unnecessary interventions to lower their testosterone levels in order to be allowed to participate in competitions, a regulation that is opposed by many including the Human Rights Watch, the Sport and Recreation Minister of South Africa, the Canadian Centre for Ethics in Sport, the Canadian Association for the Advancement of Women in Sport and Physical Activity;[12,13,14,15,16] and

Whereas, More than 200 genetic polymorphisms have been associated with improved athletic performance--such as the ACEI/I genotype that is associated with increased endurance performance--yet none of these variations lead to the disqualification of athletes;[17,18] and

Whereas, There is no upper limit for testosterone levels imposed on male athletes, and those with male hypogonadism can even apply for an exemption to take steroids to increase testosterone levels, female athletes with hyperandrogenism are disqualified unless they pursue medical treatments or surgery to lower these levels;[19] and

Whereas, The AMA has previously taken stances opposing medically unnecessary services (H-470.978, H-525.987); therefore be it

RESOLVED, That our AMA oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity; and be it further

RESOLVED, That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions; and be it further

RESOLVED, That our AMA work with relevant stakeholders to establish guidelines for international competitions that accommodate athletes with DSD.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

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.

Surgical Modification of Female Genitalia H-525.987
Our AMA (1) encourages the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications and possible corrective surgical procedures, and (2) opposes all forms of medically unnecessary surgical modification of female genitalia.

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.

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.

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;"

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 68
(I-18)

Introduced by:	Region 5; Region 7; Rohan Khazanchi, University of Nebraska Medical Center; Pauleatha Diggs, Vanderbilt University School of Medicine; Ellena Popova, University of Pennsylvania Perelman School of Medicine
Subject:	Prevent Discriminatory Increases in Insurance Cost for Patients Who Use HIV Pre-Exposure Prophylaxis (PrEP)
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

Whereas, HIV Pre-Exposure Prophylaxis (PrEP) is a combination of tenofovir and emtricitabine, which are taken to lower the risk of a person not infected with HIV from contracting HIV from a positive person;[1] and

Whereas, PrEP taken daily reduces the risk of sexually transmission of HIV by more than 90%, and transmission from injection drug users by more than 70%;[1] and

Whereas, PrEP was estimated in 2015 to be used by 80,000 individuals in the United States, which is a small proportion of the 1.2 million US residents who would benefit from PrEP usage;[2,3] and

Whereas, In 2017 the CDC showed that annual HIV infections in the United States fell 18 percent between 2008 and 2014;[4] and

Whereas, A study looking at data over 2012 and 2016 found that rates of new HIV diagnoses had the greatest decrease in states with the greatest PrEP use;[5] and

Whereas, A survey of 544 PrEP-naïve young men who have sex with men found 58.9% of participants worried that they would not be able to afford PrEP;[6] and

Whereas, There is a strong connection between health insurance coverage and utilization of PrEP, with insured patients being four times as likely to use PrEP;[7] and

Whereas, At least 16 instances have been reported in which an individual using PrEP has been denied disability, long-term care, or life insurance or provided with lower-quality or higher-cost coverage;[8,9,10] and

Whereas, Women who take preventive measures such as birth control and/or persons who receive the human papillomavirus vaccine are not denied health insurance coverage;[9] and

Whereas, Private health insurance plans are restricting the use of "copay coupons", offered by pharmaceutical companies to help offset deductible costs of PrEP medication, resulting in more financial barriers in patient access to PrEP;[11,12] and

Whereas, The AMA's current policy supports the use of and adequate insurance coverage of preventive care (H425.987); therefore be it,

RESOLVED, That the AMA amend policy H-20.895 (Pre-Exposure Prophylaxis (PrEP) for HIV) by insertion as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

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

Fiscal note: Significant, 10

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
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.

Insurance Underwriting Reform H-185.947
Our AMA: (1) urges insurance companies to recognize that some medical conditions can be resolved or reduced to the extent that they are no longer valid predictors of morbidity and mortality, (2) urges insurance companies to make underwriting decisions based only on the presence of conditions that are valid predictors of morbidity and mortality

Preventive Medicine Services H-425.987
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services.

Modernization of HIV Specific Criminal Laws 20.019MSS
AMA-MSS will ask the AMA to amend policy H20.914 via insertion and deletion as follows: H-20.914 Discrimination and Criminalization Based on HIV Seropositivity Our AMA: Remains

cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences. (MSS Res 37, I-13) (AMA Res 2, A-14 Substitute Res 2 Adopted)

Increase Access to HIV PrEP for At-Risk Individuals 20.020MSS
AMA-MSS supports PrEP referral at needle exchange sites. (MSS Res 26, A-17)

Protecting Patient Access to Health Insurance and Affordable Care 165.019MSS
AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (MSS Late Res 01, I-16 Immediate Transmittal AMA Res 224, Substitute Resolution Adopted in Lieu of Res 205, 209, 224, and 226 [D-165.93]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

Resolution: 69
(I-18)

Introduced by: Tabitha Moses, Taymaz Joneydian, Emily Lau, Lakshmi Nerusu, Brianna Sohl, Jacob Young, Jacob Wilson; Wayne State University

Subject: Enhance Protections for Patients Seeking Help for Pedophilic Urges and the Physicians Treating Them

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

Whereas, The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines pedophilic disorder as an abnormal sexual behavior with strong and recurrent sexual urges towards prepubescent children that have been acted upon or cause unsettling interpersonal conflict;[1,2] and

Whereas, Persons with pedophilic disorder may not necessarily engage in sexual crimes towards children and persons who engage in these crimes may not necessarily have pedophilic disorder;[3,4] and

Whereas, Current estimates of the incidence of pedophilic urges in the general population range between 3% and over 20% but most with these urges do not act upon them;[4,5] and

Whereas, Persons who are convicted of sexual offenses, including sexual crimes towards children, are required to register on the sex offender registry;[6] and

Whereas, Persons who are put on a sex offender registry are required to follow requirements such as following up with the local police department and keeping current information updated on the public registry regarding their address and place of employment;[7] and

Whereas, Persons who are convicted of nonviolent misdemeanor sex crimes generally have a 15-year minimum requirement to be registered on the sex offender list;[6] and

Whereas, Some states including California and South Carolina require a person convicted of any sex crime (including non-violent misdemeanors) to be placed on the sex offender registry for life;[7] and

Whereas, A study conducted by the Institution of Sexology and Sexual Medicine shows that many people who self-identify as pedophiles want to seek help;[8] and

Whereas, Many those who want to seek help may feel unable to due to fear of being reported;[9,10,11] and

Whereas, Psychiatrists are bound by certain legal and ethical obligations that require them reporting of a patient who expresses a desire to harm another person; the most famous of these laws is the Tarasoff law which states that when there is a threat of danger the duty to warn trumps patient confidentiality;[12,13] and

Whereas, The AMA Medical Code of Ethics supports this stating that "information disclosed to a physician by a patient should be held in confidence…subject to certain exceptions which are ethically justified because of overriding considerations"; these exceptions include "serious physical harm" on the self or others with a "reasonable probability that the patient may carry out the threat";[14] and

Whereas, Physicians are also mandated reporters of suspected current or potential child abuse, a category which includes child neglect and sexual, physical and psychological abuse;[15,16] and

Whereas, The specific language of many of these mandated reporting guidelines is ambiguous enough that some medical professionals feel obligated to report even pedophilic desires without intended action;[10] and

Whereas, Support groups such as Virtuous Pedophiles exist with as many as 1,200 members seeking professional help in resisting their sexual impulses as they face isolation, self-loathing, and suicidal thoughts, and testimonies from members further denote their hesitation to seek therapy due to fear of current reporting laws;[11,17,18,19] and

Whereas, Circles of Support and Accountability in Canada has trained volunteers to act as peer support, offering confidential therapy and support for offenders; this program resulted in a 70% reduction in sexual recidivism and 82% reduction in offending;[20] and

Whereas, 'Stop It Now' campaigns geared toward confidential conversation and support for offending and non-offending persons with pedophilic disorder in the UK and Ireland saw a 41% increase in utilization from 2016 to 2017, including 2,251 persons calling the help hotline with concern about their own behavior or that of a family member in 2017;[21] and

Whereas, The Prevention Project Dunkelfield in Germany offers non-judgmental, confidential therapy and libido reducing medication for offending and non-offending individuals;[8] and

Whereas, A study of the Prevention Project Dunkelfield showed that over half of participants were non-offenders, had sought professional help previously and never had contact with a minor;[8] and

Whereas, Several cognitive-behavior therapies- including relapse-prevention and aversion therapy- have been shown to be effective in treating pedophilic urge and action and prevent future encounters with prepubescent children; [8,22] and

Whereas, Several drug-based therapies- including androgen deprivation therapy and selective serotonin reuptake inhibitors (SSRIs)- have been shown positive results in treating pedophilic offenders and non-offenders;[23,24] therefore be it

RESOLVED, That our AMA support legal protections from malpractice suits and criminal liability for psychiatrists confidentially treating patients with unexpressed destructive desires; and be it further

RESOLVED, That our AMA advocate for increased training and awareness about the incidence of these desires in the general population and potential treatment options; and be it further

RESOLVED, That our AMA support confidential prophylactic treatment of people with pedophilic disorder.

Fiscal note: Significant, 12

Date received: 09/23/18

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RELEVANT AMA AND AMA-MSS POLICY:

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

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.

Protection of Health Care Providers from Unintended Legal Consequences of HIPAA D-190.983
Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION

INTERIM, 2018 REPORTS

MSS Governing Council Report A:
Policy Sunset Report for 2013 AMA-MSS Policies

MSS Governing Council Report B:
Pilot Implementation of the 2018 Resolution Task Force Recommendations Update

MSS Committee on Medical Education Report A:
Requiring Blinded Review of Medical Student Performance

MSS Committee on LGBTQ+ Issues Report A:
Gender and LGBTQ+ Discrimination in Income

MSS Committee on LGBTQ+ Issues and Minority Issue Committee Joint Report A:
Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

MSS Committee on Health Information Technology Report A:
Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication

MSS Committee on Health Information Technology and Committee on Economics and Quality in Medicine Joint Report A:
Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized Technology

MSS Committee on Economics and Quality in Medicine Report A:
Increased Affordability and Access to Hearing Aids

MSS Committee on Global and Public Health Report A:
Adverse Impacts of Delaying the Implementation of Public Health Regulations

REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report A, I-18

Subject: Policy Sunset Report for 2013 AMA-MSS Policies

Presented by: Karen Dionesotes, Chair

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At the 1995 Medical Student Section (MSS) Interim Meeting, a sunset mechanism for MSS policy was established per MSS COLRP Report B-I-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 2013, the recommendation for retention or rescission, and a brief supporting rationale for that recommendation. Many 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.

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.

Appendix 1 – Policy Sunset Report Recommendations for 2013 AMA-MSS Policies

	Policy No.	Policy Description	GC Recommendation
1	10.009MSS	Use of Protective Eyewear by Young Athletes: AMA-MSS will ask the AMA to establish policy in support of the use of protective eyewear for athletes who have had eye surgery or trauma, or are functionally one-eyed individuals, and for all other athletes engaged in high eye-risk sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology. (MSS Sub Res 15, A-98) (AMA Amended Res 404, I-98, Adopted [H-10.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Sunset, Policy was Accomplished
2	10.013MSS	Implementing Bike Lanes to Improve Overall Bicyclist Safety: AMA-MSS supports research on the safety and efficacy of the implementation of various forms of bicycle lanes in reducing crash incidence and severity. (MSS Res 39, I-13)	Retain - Policy is still relevant
3	20.005MSS	Drug Availability: AMA-MSS will ask the AMA, as set forth in its objective of contributing to the betterment of the public health, to: (1) use its resources in cooperation with other health care organizations and agencies to facilitate the distribution of information on drug therapy availability for AIDS; and (2) encourage the FDA to continue to	Retain - Policy is still relevant

		expedite the evaluation of available drugs used in the treatment of AIDS (AMA Res 177, A-88 Adopted as Amended [H-20.922]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
4	20.006MSS	AIDS Prevention Through Educational Programs: AMA-MSS will ask the AMA to support attention to language and cultural appropriateness in HIV educational materials and encourage the development of additional materials designed to inform minorities of risk behaviors associated with HIV infection. (AMA Res 121, I-88 Adopted [H-20.904]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
5	20.019MSS	Modernization of HIV Specific Criminal Laws: AMA-MSS will ask the AMA to amend policy H-20.914 via insertion and deletion as follows: H-20.914 Discrimination and Criminalization Based on HIV Seropositivity Our AMA: Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV	Retain - Policy is still relevant

		seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences. (MSS Res 37, I-13) (AMA Res 2, A-14 Substitute Res 2 Adopted)	
6	30.006MSS	Support of Programs that Discourage Adolescent Alcohol Consumption: AMA-MSS strongly encourages AMA-MSS ~~chapters~~ local sections to work with adolescents in their local communities in order to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations. (MSS Res 28, I-03) (Reaffirmed: MSS Rep E, I-08) Modified: MSS GC Rep B, I-09)	Modify and Retain- Policy is still relevant but requires updated language

		(Reaffirmed: GC Rep B, I-13)	
7	55.004MSS	Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia: AMA-MSS will ask the AMA to support continued research on the diagnosis and treatment of anal cancer and its precursor lesions and to promote awareness of the current research regarding the utility of anal pap smears as a screening tool for anal cancer. (MSS Rep C, I-03) (AMA Amended Res 512, A-04 Adopted [H-460.913]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
8	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])	Retain - Policy is still relevant

		(Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13	
9	65.009MSS	Same-Sex and/or Opposite Sex Non-Married Partner: AMA-MSS will ask the AMA to support legislative and other efforts to allow the adoption by the same-sex and/or opposite sex non-married partner who functions as a second parent or co-parent of children who are born to or adopted by one member. (MSS Res 24, I-03) (AMA Res 204, A-04 Adopted [H-60.940]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Sunset, Policy Accomplished
10	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)	Sunset, Policy Accomplished

11	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)	Retain- Policy is still relevant
12	75.005MSS	Promotion of Emergency Contraception Pills: AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women's groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need. (MSS Sub Res 54, I-98) (AMA Amended Res 403, A-99 Adopted [D-75.999]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (D-75.999 Rescinded: CSAPH Rep. 1, A-09) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

13	75.008MSS	Opposition to Sole Funding of Abstinence-Only Education: AMA-MSS will ask the AMA to actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes. (MSS Res 31, A-03) (AMA Amended Res 441, I-03 Adopted [H-170.968]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
14	75.009MSS	Ending Discrimination Against Contraception: AMA-MSS will ask the AMA to support the concept of equity among all forms of prescription contraception in order to offer women the option of affordable contraceptives which would include support from state and federal agencies. (MSS Res 34, I-03) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-04) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

15	90.001MSS	Handicapped Parking Spaces: AMA-MSS will ask the AMA to support efforts to educate the public on the appropriate use of parking spaces for the handicapped. (AMA Res 118, I-88 Adopted [H-90.991]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (H-90.991 Rescinded: CCB/CLRPD Rep. 3, A-14)	Sunset, HOD Policy H-90.991 Rescinded
16	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)	Sunset, Superseded by 100.021MSS Opposing the Classification of Cannabidiol as a Schedule 1 Drug
17	100.005MSS	Informational Campaign on Diethylstilbestrol - (DES): AMA-MSS will ask the AMA to: (1) encourage education on the consequences of diethylstilbestrol exposure so that medical students and health care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children; and (2) support research efforts on DES exposure and the future health of those affected. (MSS Amended Res 1, A-98) (AMA Amended Res 50, I-98 Adopted [H-100.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

18	120.005MSS	Tracking and Punishing Distributors of Counterfeit Pharmaceuticals: AMA-MSS will ask the AMA to support the Food and Drug Administration's efforts to research a uniform tracking system for pharmaceuticals and legislation making the production and distribution of counterfeit pharmaceuticals a felony. (MSS Res 35, I-03) (AMA Amended Res 924, I-03 Adopted [D-100.988]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
19	130.002MSS	Use of Automatic External Defibrillators: AMA-MSS will ask the AMA to support legislation for the increased use of automatic external defibrillators (AEDs) for the purpose of saving the life of another person in cardiac arrest provided that: (1) A person or entity who acquires an automatic external defibrillator ensures that: (A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer's operational guidelines; and (C) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible. (2) Any person or entity who acquires an automatic external defibrillator is encouraged to register the existence and location of the defibrillator with the emergency communications district or the	Retain, Policy is still relevant

		ambulance dispatch center of the primary provider of emergency medical services where the automatic external defibrillator is to be located. (MSS Sub Res 12, A-98) (AMA Res 503, I-98 Referred) (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
20	140.027MSS	Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education: AMA-MSS will as the AMA to (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with appropriate AMA-MSS bodies, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the ASBH Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools. (MSS Res 6, A-13) (AMA Policy H-295.961 Reaffirmed in Lieu of AMA Res 902, I-13)	Sunset, accomplished H-295.961 remains AMA Policy
21	145.011MSS	Gun Safety Counseling in Undergraduate Medical Education: AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education;	Retain - Policy is still relevant

		(2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976])	
22	150.004MSS	Food Substitutes: AMA-MSS will ask the AMA to continue to monitor ongoing studies and future developments concerning substitutes for fat, flour and butter so that physicians can be informed about potential health risks or benefits to their patients before these products are released to the public market. (AMA Res 176, A-88 Adopted [H-150.976]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Sunset, accomplished. AMA Policy H-150.976 sunset
23	150.012MSS	Allergic Reactions in Schools and Airplanes: AMA-MSS will ask the AMA to recommend that (1) all schools provide increased student education on the danger of food allergies; (2) all schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration, be trained and certified in the indications for and techniques of their use; and (3) all commercial	Retain - Policy is still relevant

		airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. (MSS Res 33, A-03) (AMA Amended Res 415, A-04 Adopted [H-440.884]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	
24	150.013MSS	Mercury in Food as a Human Health Hazard: (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 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)	Retain- still relevant AMA Policy H-150.947

25	150.014MSS	Healthy Food Options in Hospitals: AMA-MSS will ask the AMA to encourage that healthy food options be available, at reasonable prices and easily accessible, on hospital premises. (MSS Res 21, I-03) (AMA Res 410, A-04 Adopted [H-150.949]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant
26	160.009MSS	Complete Federal Responsibility for Medical Translation Services: AMA-MSS believes that neither physicians nor patients should be expected to fund translation services for their patients as Department of Health and Human Services' policy guidance currently requires. (MSS Res 30, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: MSS GC Report B, I-13)	Retain - Policy is still relevant
27	160.028MSS	Improving Home Health Care: AMA-MSS will ask the AMA to support the establishment of state-based certification for home health care workers and regulatory oversight over home health agencies. (MSS Res 11, I-13) (AMA Res 703, A-14 Referred)	Retain- Policy is still relevant

28	165.003MSS	Advocacy For Rapid And Timely Implementation Of The State Children's Health Insurance Program: AMA-MSS will actively promote the rapid and timely enrollment of eligible children in their State Children's Health Insurance Program through its State Medical Student Sections and local sections~~chapters~~. (MSS Sub Res 11, I-98 Adopted) (Reaffirmed Existing Policy in Lieu of AMA Res 104, A-99) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Modify and Retain- Policy is still relevant but requires updated langauge
29	170.008MSS	Increasing HPV Education: AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education. (MSS Sub Res 37, I-98) (Reaffirmed Existing Policy in Lieu of AMA Res 405, A-99) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
30	170.014MSS	Recognizing the Importance of the Theory of Evolution in Science Education: AMA-MSS will ask the AMA to endorse the teaching of the theory of evolution as an integral part of science education. (MSS Amended Res 21, I-08) (Existing Policy Reaffirmed in Lieu of AMA Res 514, A-09) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
31	180.004MSS	Sexual Orientation as Health Insurance Criteria: AMA-MSS will ask the AMA to oppose denial of health insurance on the basis of sexual orientation. (AMA Res 178, A-88 Adopted [H-180.980]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03)	Retain - Policy is still relevant

		(Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	
32	180.015MSS	Privacy Issues for Minors Regarding Insurance Company Explanations of Benefits: AMA-MSS will ask the AMA to (1) advocate for maintaining privacy regarding the doctor patient relationship for adults and dependents who are insured through their spouse, parent, or guardian, respectively; (2) advocate against allowing insurance companies to send Explanations of Benefits containing sensitive medical information regarding both adults and dependents to anyone other than the patient or their health care provider; and (3) advocate that Explanations of Benefits be made available only if an insurance claim has been denied, in which case the information should be sent directly to the (adult or dependent) patient, who may then choose to discuss it with their physician or share it with their spouse, parent, or guardian. (MSS Res 11, A-13) (AMA Res 801, I-13 Referred)	Retain- Policy is still relevant
33	200.002MSS	Support of the NHSC Loan Repayment Program: AMA-MSS will ask the AMA to support the continuation and expansion of the NHSC loan repayment program. (MSS Amended Res 3, I-89) (AMA Res 120, A-90 Adopted as Amended [H-200.984]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

34	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)	Retain - Policy is still relevant
35	215.002MSS	Studying Hospital-Enforced Admissions, Testing, and Procedure Quotas: AMA-MSS will ask the AMA to study the extent to which U.S. hospitals inappropriately interfere in physicians' independent exercise of medical judgment, including but not limited to the use of admissions, testing, and procedure quotas. (MSS Res 19, I-13)	Retain - Policy is still relevant
36	215.003MSS	Preventive Screening and Treatment of Malnutrition in Hospital Patients: AMA-MSS will ask the AMA to (1) support the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals; (2) support the establishment of national registries for the sharing of information on prevalence of malnutrition, health outcomes, costs, and other metrics associated with the performance of nutrition support teams and other preventive nutritional interventions; and (3) support the reimbursement of assessment and interventions	Retain - Policy is still relevant

		provided by nutrition support teams as preventive services where they are used to preclude or mitigate adverse health outcomes, rather than manage disease-related malnutrition. (MSS Res 29, I-13)	
37	245.006MSS	Detection, Diagnosis And Intervention Of Hearing Loss In Newborns And Infants: AMA-MSS will ask the AMA to support the establishment of statewide programs for the early detection and diagnosis of hearing loss as well as interventional programs for all affected newborns and infants. (MSS Late Res 11, I-98) (AMA Res 435, I-98 Referred) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
38	245.012MSS	Continuing the Fight to Lower Infant Mortality in the United States: 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)	Retain - Policy is still relevant

39	250.010MSS	Medical Supply Donations to Foreign Countries: (1) AMA-MSS will ask the AMA to encourage the continuing donation of medical equipment, drugs, computers, textbooks, and any other unused medical supplies. (2) AMA-MSS encourages chapters to collect medical supplies from their local physicians, hospitals, clinics, etc. (MSS Amended Res 61, I-98) (AMA Res 608, A-99, Referred for decision) (BOT Adopted AMA Res 608, A-99 [D-250.992]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant
40	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)	Sunset, D-245.997 Rescinded: CCB/CLRPD

41	250.019MSS	Global HIV/AIDS Prevention: AMA-MSS will ask the AMA to (1) support 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; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (MSS Late Res 3, A-08) (AMA Res 438, A-08 Withdrawn) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
42	250.024MSS	Regulations in Times of Armed Conflict: AMA-MSS will ask the AMA to (1) endorse the World Medical Association's "Regulation in Times of Armed Conflict" as policy on the topic of medical neutrality; and (2) advocate that the United States use its voice in international affairs to protect medical neutrality. (MSS Res 22, A-13) (AMA Policy H-520.998 Reaffirmed in Lieu of AMA Res 601, I-13)	Retain - Policy is still relevant
43	255.004MSS	United Nations Population Fund: AMA-MSS will ask the AMA to: (1) support reinstitution of U.S. funding to the United Nations Fund for Population Activities or other United Nations population and reproductive health programs consistent with AMA policy; and (2) educate its members about the possible consequences of the withdrawal of U.S. funding from the United Nations Fund for Population Activities and its support for the reinstitution of such funding. (MSS Rep B, I-03) (AMA	Sunset, HOD Policy Rescinded

		Res 441, A-04 Adopted [D-250.994]) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (D-250.994 Rescinded: CSAPH Rep 1, A-14)	
44	270.016MSS	Hate Crimes: AMA-MSS will ask the AMA to recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States. (MSS Amended Late Res 8, I-98) (AMA Amended Sub Res 228, I-98 Adopted [H-65.980]) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant
45	270.020MSS	Professional Promotion Disclosure Registry: AMA-MSS supports initiatives to create an enforced, transparent, and publicly accessible national registry that would document and itemize individual gifts and payments to physicians from the pharmaceutical, device, and biologic industries; and (2) supports the development of specifications outlining criteria that should be included in any professional promotion disclosure registry in terms of enforcement, transparency, public availability, and reported payments (in accordance with AMA ethical guidelines depicting appropriate payments) to optimize and unify various professional promotion monitoring systems without jeopardizing prescriber-identifiable data. (MSS Rep C, I-08) (AMA Res 6, A-09 Not Adopted)	Retain, Policy is still relevant

		(Modified: GC Rep B, I-13)	
46	275.009MSS	Voting Rights For AMA-MSS NBME Representatives: (1) AMA-MSS will ask the AMA to: (a) petition the NBME to add AMA student representation to the National Board, the governing and voting body of the NBME; (b) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (2) The AMA-MSS Governing Council will pursue avenues to obtain AMA-MSS representation on the NBME Board. (MSS Amended Sub Res 10, I-98) (AMA Res 323, I-98 Adopted [H-295.893]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Sunset, H-295.893 Rescinded: CME Rep. 01, A-18
47	295.012MSS	Promotion of Infection Control Procedures in the Medical School Setting: AMA-MSS will ask the AMA to: (1) encourage training in infection control to occur throughout the medical school curriculum; (2) urge teaching hospitals to be equipped with the necessary supplies to comply with the Center for Disease Control infection control recommendations; and (3) urge medical schools to integrate a student's use of proper infection control techniques in the student's evaluations. (MSS Rep G, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

48	295.090MSS	Status of Graduates of Puerto Rico LCME Medical Schools: AMA-MSS will direct its liaison to the LCME to remind U.S. medical schools and residency programs that LCME accredited schools in the Commonwealth of Puerto Rico are considered part of the U.S. educational system and not that of a foreign entity and that students from these programs should be treated as U.S. students. (MSS Sub Res 17, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant
49	295.093MSS	FREIDA Online: AMA-MSS will promote the use of AMA FREIDA Online. (MSS Rep D, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B-I-13	Retain - Policy is still relevant
50	295.098MSS	Distribution of the AMA Code of Medical Ethics: AMA-MSS will ask the AMA to distribute unannotated copies of the Code of Medical Ethics to every first-year medical student. (MSS Sub Res 38, I-98) (AMA Amended Res 605, A-99 [D-140.995]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Sunset, D-140.995 Rescinded CEJA Rep. 8, A-09

51	295.101MSS	Support for the Accreditation of US Medical Schools: AMA-MSS recommends that as new medical schools are established in the US, they should be encouraged to apply for LCME or AOA accreditation. (2) AMA-MSS will join efforts to educate the public, physicians, health policy leaders, educators, and elected officials about the need to maintain quality standards in medical education. (3) AMA-MSS will encourage and will ask the AMA to encourage efforts to educate all prospective medical students about the potential implications of attending any non-LCME/AOA accredited medical school. (MSS Amended Sub Res Late 6, I-98) (AMA Amended Res 322, I-98 Adopted [H-295.892]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant

52	295.114MSS	Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation: (1) AMA-MSS will ask the AMA to: (a) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam (USMLE) Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (b) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (c) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first 5 years of the implementation of the exam; (d) encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in	Sunset- 1) The AMA policy created by this was rescinded in 2013, and this would be consistent with other instances above. 2) The MSS more recently has passed policy calling for the elimination of these exams (275.011 MSS) That policy to me seems to supersede this policy.

		medical schools; (e) study, in conjunction with the NRMP, AOA, AGCME, and other interested organizations, the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education; (f) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and (g) monitor in an ongoing fashion, the implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum. (2) AMA-MSS will study safeguard measures for students in the first five years of implementation of the Clinical Skills Assessment Exam and COMLEX-PE; (MSS Res 7, A-03) (AMA Amended Res 324, A-03 Adopted in Lieu of Resolution 315 [D-275.985]) (Amended: MSS Rep E, I-08) (D-275.985 Rescinded: CME Rep. 2, A-13) (Reaffirmed: GC Rep B, I-13)	
53	295.115MSS	Support of Business of Medicine Education for Medical Students: AMA-MSS will ask the AMA to 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	Retain - Policy is still relevant

		students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (MSS Res 1, I-03) (AMA Res 305, A-04 Adopted [D-295.958]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-295.958 Rescinded: CME Rep. 2, A-14)	
54	295.116MSS	Opposition to Clinical Skills Examinations for Physician Medical Re-Licensure: AMA-MSS will ask the AMA to: (1) oppose clinical skills examinations for the purpose of physician medical re-licensure until such examinations can be shown to accurately predict physician clinical incompetence or moral turpitude; (2) reaffirm its support for continuous quality improvement of practicing physicians; and (3) support research into methods to improve clinical practice, including practice guidelines and continue to support the implementation of quality improvement through local professional, non-governmental oversight. (MSS Res 13, I-03) (AMA Amended Res 307, A-04 Adopted in lieu of AMA Res 313 [H-275.930]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
55	295.117MSS	Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam: AMA-MSS will ask the AMA to oppose additions to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam that lack predictive validity for future performance as a physician and work with appropriate organizations toward requiring consensus approval by professional medical organizations for implementation of	Retain - Policy is still relevant

		additions or modifications to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam. (MSS Res 14, I-03) (AMA Amended Res 308, A-04 Adopted [H-275.929]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
56	295.126MSS	Medical Student Clinical Training and Education Conditions: AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call; and (2) recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision. (MSS Res 16, I-03 Referred) (AMA Res 310, A-04 Referred) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
57	295.141MSS	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	Retain - Policy is still relevant

		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)	
58	295.145MSS	One Health: AMA-MSS will engage in dialog with the Student American Veterinary Medical Association to promote collaboration with the public health and veterinary professional and educational communities. (MSS Res 12, A-08) (Modified: GC Rep B, I-13)	Retain - Policy is still relevant
59	295.174MSS	Evaluation of Standardized Clinical Skills Exams: AMA-MSS will ask the AMA to (1) evaluate the benefits and consequences of the implementation of the standardized clinical skills exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills Exam and their implications for US medical students. (MSS Res 7, A-13) (AMA Res 904, I-13 Adopted [D-295.960])	Sunset- The MSS more recently has passed policy calling for the elimination of these exams (275.011 MSS) That policy to me seems to supersede this policy.
60	295.175MSS	Medical Student Mistreatment: AMA-MSS will encourage medical schools to have procedures in place for students to report incidents of mistreatment without fear of retaliation and that instructions on how to report incidents should be explained to students at the beginning of medical school and again before starting rotations. (MSS Res 3, I-13)	Retain - Policy is still relevant

61	295.176MSS	Unified Medical Education: AMA-MSS supports a Unified Accreditation System for allopathic and osteopathic graduate medical education programs. (MSS Res 5, I-13)	Retain - Policy is still relevant

62	295.177MSS	Shared Decision-Making in Medical Education: AMA-MSS will ask the AMA to (1) amend policy D.373.999 by insertion as follows: D-373.999 Informed Patient Choice and Shared Decision Making (1) Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care; and (2) Collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids. (MSS Res 21, I-13; Res. 817, I-08 [D-373.999])	Retain - Policy is still relevant
63	295.178MSS	Motivational Interviewing in Medical Education: AMA-MSS supports the incorporation of motivational interviewing into medical school curriculum. (MSS Res 27, I-13)	Retain - Policy is still relevant

64	305.050MSS	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)	Retain - Policy is still relevant
65	305.050MSS	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)	Retain - Policy is still relevant

66	305.052MSS	Reduction in Student Loan Interest Rates: (1) 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 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)	Retain - Policy is still relevant
67	305.054MSS	Refinancing Federal Consolidation Loans: AMA-MSS will ask the AMA to support the refinancing of Federal Consolidation Loans and actively advocate for legislation that provides the opportunity to refinance Federal Consolidation Loans. (MSS Res 7, I-03) (AMA Res 849, I-03 Adopted [D-305.981]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant

68	305.060MSS	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)	Retain - Policy is still relevant

69	305.062MSS	Industry Support of Professional Education in Medicine: AMA-MSS encourages aggressively decreasing reliance on industry support for medical education and support alternative funding mechanisms to finance quality medical education. (MSS Res Late 4, A-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
70	310.024MSS	Resident Physician Organizations: AMA-MSS supports the formation of independent house staff organizations. (MSS Sub Res 33, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
71	310.031MSS	Resident/Fellow Work and Learning Environment: (1) AMA-MSS will ask the AMA continue to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation; (2) AMA-MSS will (a) continue to work, along with AMA-RFS, with groups such as the Committee of Interns (CIR) on collaborative efforts to see that duty hour reform is enforced and (b) continue to work to improve working conditions for residents and fellows. (MSS Rep D, A-03) (AMA Amended Res 322, A-03 Adopted; Resolve 8, Referred) (Amended: MSS Rep E, I-08) (Modified: GC Rep B, I-13)	Retain - Policy is still relevant

72	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)	Retain - Policy is still relevant
73	350.011MSS	Continued Support for Diversity in Medical Education: 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 [D-295.963]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS Res 27, I-15)	Retain - Policy is still relevant

74	370.013MSS	Presumed Consent Organ Donation: AMA-MSS will ask the AMA to reexamine the ethical considerations of presumed consent and other potential models for increasing the United States organ donor pool. (MSS Res 1, I-13)	Sunset, Ethics Opinion 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors issued 2016
75	385.002MSS	The Patient-Centered Medical Home Concept: AMA-MSS will ask the AMA to (1) Adopt the following definition of the patient-centered medical home model as set forth by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association in the Joint Principles of the Patient-Centered Medical Home: (a) Personal physician (b) Physician directed medical practice (c) Whole person orientation (d) Care is coordinated and/or integrated (e) Quality and safety (f) Enhanced access (g) Payment; (2) Continue to support the Medicare Medical Home Demonstration project and study the implications of including "payment" as a principle in the definition of the patient-centered medical home model; and (3) Advocate that every American have access to medical services within the setting of a	Retain - Policy is still relevant

		patient-centered medical home. (MSS Sub Res 4, A-08) (AMA Res 804 adopted in lieu of AMA Res 820, I-08 [H-160.919, D-160.942]) (Reaffirmed: GC Rep B, I-13)	
76	420.006MSS	High Rates of Cesarean Deliveries: AMA-MSS will ask the AMA to (1) support the American Congress of Obstetricians and Gynecologists' 2013 opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and (2) encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use. (MSS Res 10, I-13) (AMA Res 706, A-14 Not Adopted)	Sunset, ACOG has since updated their opinions dating this policy. Modification of this resolution could result in overstepping of the mechanism of the sunset report.
77	420.007MSS	Providing Complete Maternity Care Under the Affordable Care Act: AMA-MSS will ask the AMA to advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans. (MSS Res 13, I-13) (AMA Res 101, A-14 Adopted [H-185.997])	Retain - Policy is still relevant
78	435.004MSS	A No-Fault Professional Liability System: AMA-MSS will ask the AMA to encourage state-based demonstration projects of a no-fault medical professional liability system as the preferred mechanism for improving patient safety, efficiently compensating injured patients, and reducing the substantial costs of defensive medicine and litigation to	Retain - Policy is still relevant

		our healthcare system.(MSS Res 28, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
79	435.009MSS	Liability Coverage for Medical Students Completing Extramural Electives: (1) AMA-MSS will (a) encourage the Association of American Medical Colleges to increase the utility of its Extramural Electives Compendium (EEC) by providing information regarding liability coverage requirements at all host institutions and by making this a searchable feature, and additionally that the AMA-MSS provide a link to the EEC on its Web site; and (b) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; and (2) AMA-MSS will ask the AMA to (a) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; (b) examine whether or not students have been found partially accountable in recent malpractice suits, as well as the appropriateness of the amounts of medical student	Retain - Policy is still relevant

		liability coverage required by medical schools with respect to the current medical professional liability insurance market; and (c) examine the propriety of schools requiring their own and visiting students to carry levels of medical liability coverage in excess of the minimum amounts mandated for physicians by state law. (MSS Rep C, A-08) (AMA Res 913 Referred) (Reaffirmed: GC Rep B, I-13)	
80	440.012MSS	Public Education Announcements for Detection of Skin Cancer: AMA-MSS will ask the AMA to support a public service announcement to increase public awareness of the high incidence of skin cancer, complications of skin cancer and how to do home screening and routine self-exams for the early detection of skin cancer. (MSS Res 23, A-98) (Existing Policy Reaffirmed in Lieu of AMA Res 406, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
81	440.013MSS	Obesity as a Chronic Disease: 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)	Retain - Policy is still relevant

		(Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
82	440.019MSS	Requirement for Daily Free Play in Schools: AMA-MSS will ask the AMA to: (1) recommend that elementary schools maintain at least thirty minutes of daily free play during each school day; and (2) work with other interested medical societies to urge the Department of Education and state and national legislatures to enact regulatory and legislative provisions that ensure at least thirty minutes of daily free play for elementary school students. (MSS Res 20, I-03) (AMA Amended Res 409, A-04 Adopted [H-470.961 and D-470.994]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)	Retain - Policy is still relevant
85	440.020MSS	Support for Needlestick Prevention: AMA-MSS strongly supports the implementation of needlestick prevention devices, including but not limited to retractable needles or needleless systems, with the participation of physicians and other health care workers who will use such devices and, where appropriate, the introduction of such devices accompanied by the necessary education and training as part of a comprehensive sharps injury prevention and control program. (MSS Res 29, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

86	440.032MSS	Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance: AMA-MSS will ask the AMA to work with interested partners in the Federation of Medicine to develop formal recommendations, based on a review of the evidence and expert clinical judgment, to develop and/or improve new or existing FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial-resistant pathogens. (MSS Res 1, A-08) (AMA Res 530, A-08 Adopted as Amended [D-100.976]) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
87	440.044MSS	Sunscreen and Sun Protection Counseling by Physicians: AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sub-protective behavior. (MSS Res 26, I-13)	Modify and Retain, correction
88	440.045MSS	Development of a Standardized Post-Conducted Electrical Device Exposure Medical Protocol and Educational Campaign: AMA-MSS will ask the AMA to (1) encourage appropriate organizations and medical specialty societies to develop a standardized, post-exposure medical protocol for the use of conducted electrical devices (CEDs) using recent advances in the	Modify and Retain, correction

		understanding of the risks associated with CEDs; and (2) support the incorporation of a standardized post-conducted electric device (CED)-exposure medical protocol into law enforcement procedures and training. (MSS Res 28, I-13)	
89	440.046MSS	Prevention of Mosquito Transmitted Diseases: AMA-MSS will ask the AMA to encourage physicians to discuss and promote protective practices specific for mosquitoes, such as those developed by the Centers for Disease Control, with patients when clinically appropriate. (MSS Res 36, I-13)	Retain - Policy is still relevant
90	460.005MSS	Scientific Implications of Somatic Cell Nuclear Transfer Technology: AMA-MSS will ask the AMA to: (1) recommend a cessation of human somatic cell nuclear transfer research by both public and private sectors that involves the production of human beings; (2) work closely with the federal research funding agencies (NIH, NSF, NCI) and the Food and Drug Administration to determine if longitudinal animal studies indicate that nuclear transfer technology is safe and reproducible; and (3) encourage the applications of nuclear transfer technology for uses other than human reproduction by supporting basic science research programs that pursue medically therapeutic procedures such as organ or tissue transplantation. (MSS Sub Res 11, A-98) (AMA Res 11, A-98 Adopted [H-460.915]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13))	Retain - Policy is still relevant

91	460.009MSS	Support for Increase in Federal Funding for the National Institutes of Health: AMA-MSS supports sufficient increases in National Institutes of Health funding to cover the rising cost of research. (MSS Sub Res 9, A-08) (Existing Policy Reaffirmed in Lieu of AMA Res 912, I-08) (Modified: GC Rep B, I-13)	Retain - Policy is still relevant
92	460.011MSS	Comparative Effectiveness Research: It is policy of the AMA-MSS to support the creation of an independent organization that: (1) Conducts and supports research into the comparative effectiveness and cost effectiveness of new and existing medical interventions to increase information available for clinical decision-making; (2) publicly disseminates findings to medical professionals and patients; (3) involves representatives of physicians and patients in its governance; (4) ensures that all studies maintain the highest standards of scientific credibility and investigator integrity, including submission of studies through a peer-review process and rules regarding conflicts of interest; (5) receives funding from a dedicated funding source or sources not subject to Congressional appropriations; (6) recognizes that patients are unique individuals and while attempting to provide evidence for specific subgroups and circumstances, acknowledges that population-level research is not applicable to every clinical case; (7) does not make recommendations for public or private insurance coverage decisions or payment policies; and (8) does not issue physician practice guidelines. (MSS Amended Res 18, I-08) (Reaffirmed: MSS GC Report	Retain - Policy is still relevant

		B, I-13)	
93	460.105MSS	Use of Animals in Research and Education: (1) AMA-MSS encourages medical school faculty who use non-human animals in the training of students to instruct students about the appropriate use of animals as experimental subjects and encourages students and faculty to play an active role at their schools in developing institutional policies governing use of animals in laboratories and other classes at their schools; and (2) AMA-MSS will make a substantial effort to educate medical students about the necessity of well-designed and humane use of animals in research and education. (AMA Amended Res 93, I-83 Adopted [H-460.989]) (MSS Sub Res 4, A-88) (MSS Rep F, A-88) (Consolidated MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Sunset- effectively changed in relevant AMA policies
94	470.003MSS	Pre-Participation Screening in Student Athletes: AMA-MSS will ask the AMA to: (1) support the inclusion of the American Heart Association screening guidelines in the standardized pre-participation athletic examination for student athletes; and (2) recommend the use of further diagnostic modalities for those student athletes identified to be at risk by the American Heart Association screening guidelines, history, or physical examination. (MSS Amended Res 8, A-98) (AMA Res 409, I-98 Referred) (Reaffirmed:	Retain - Policy is still relevant

		MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13)	
95	470.007MSS	Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention: 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])	Sunset, H-470.957 rescinded CSAPH Rep. 3, A-15
96	480.013MSS	The Role of Medical Students in the Development of Health Information Technology: AMA-MSS will work with our AMA and other relevant organizations to (a) facilitate active and timely medical student input on Health Information Technology research and development; and (b) continually determine how best our AMA-MSS can assist in the improvement of Health Information Technology. (MSS Res 31, I-13)	Retain - Policy is still relevant
97	490.018MSS	State Tobacco Tax Increases and Responsible Use of Resulting Funds: AMA-MSS will ask the AMA to support increases in the taxation of tobacco products with revenue from any such tax increases appropriated exclusively for the following uses: (1) educational, counter advertising and cessation	Retain - Policy is still relevant

		programs designed to decrease the prevalence or the adverse effects of tobacco use, and (b) health related costs associated with tobacco use (MSS Res 8, A-03) (AMA Res 803, I-03 Referred to BOT) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
98	490.019MSS	Use of State Tobacco Tax Revenue and Tobacco Settlement Fund Tracking and Publishing: AMA-MSS will ask the AMA to work with other interested organizations to seek and publish state by state accounting information regarding the specific uses of all state tobacco taxes and tobacco settlement funds. (MSS Res 9, A-03) (Reaffirmed Existing Policy in Lieu of AMA Res 804, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
99	490.020MSS	Fighting Securitization of Tobacco Settlement Funds: AMA-MSS strongly opposes the securitization of tobacco settlement funds and supports the AMA in encouraging the issue of strong public statements condemning the growing movement to “securitize” tobacco settlement funds as a one-time fix for budget problems. (MSS Res 11, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant

100	505.011MSS	Opposing the Sale of Tobacco in Retail and Grocery Stores: AMA-MSS will ask the AMA to support that the sale of tobacco products be restricted to tobacco specialty stores (MSS Res 37, I-03) (AMA Res 413, A-04 Adopted [H-495.986]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
101	630.011MSS	Improved Access and Programming of Non-Scientific Issues in Medicine: AMA-MSS will: (1) explore better methods of disseminating information from the AMA-MSS to local ~~chapters~~ sections with the goals of increased access, and program development; and (2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the lifestyles of various specialties, medicine and the media, medical economics, etc. (MSS Res 14, I-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Modify and Retain- Policy is still relevant, but requires updated language

102	630.049MSS	<u>AMA Medical Student Section Vision Statement:</u> The AMA-MSS supports the following vision statement for the AMA-MSS: (1) The AMA-MSS core purpose is: the AMA-MSS is dedicated to representing medical students, improving medical education, developing leadership and promoting activism for the health of America; (2) The AMA-MSS Envisioned Future is: The AMA-MSS strives to be the medical students' leading voice for improving medical education, advancing health care and advocating for the future of medicine.; (3) The AMA-MSS Objectives are: (a)The leading medical student organization for advancing issues of public wellness, community service, ethics, and health policy; (b) The principal source for obtaining and disseminating information for medical students regarding medical education, residency training, and medical practice; (3) The most representative voice and influential advocate for medical students and their patients; and (4) A dynamic organization that provides value to its medical student members; and (4) The AMA-MSS Core Values are: (a) *Advocacy:* Caring advocates for our patients, our profession, and our medical student members. (b) *Leadership:* The stewards of the future of medicine. (c) *Excellence:* Commitment to provide the highest quality service, products, and information for our members. (d) *Integrity*: Ethical behavior forms the basis for trust in all our relationships and actions. (MSS COLRP Rep B, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain- Policy is still relevant

103	630.050MSS	Creating a Community Service Project: AMA-MSS will undertake a limited local service project as part of its agenda at its Annual and Interim Meetings, at a time determined by Governing Council, as appropriate based on the schedule of activities. (MSS Sub Res 16, A-98) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
104	630.051MSS	AMA-MSS Digest of Actions: It is the policy of the AMA-MSS that the AMA-MSS Internal Operating Procedures and Digest of Actions be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly. (MSS Sub Res 21, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
105	640.003MSS	States Regional Chairs: AMA-MSS, through Regional Chairs will: (1) continue to encourage the development of local MSS sections and state MSS sections in medical schools and states where they do not exist; (2) involve highly organized MSS local sections and state sections in providing organizational information and assistance to developing chapters and sections; (3) encourage local MSS sections to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs. (MSS Rep K, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS	Modify and Retain, correction from “chapters” to “local sections”

		Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified and Retained: MSS GC Rep D, I-15)	
106	645.013MSS	Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD: AMA-MSS will conduct an open hearing on Saturday at each Annual and Interim meeting, to hear pertinent items of business that will be coming before the AMA-HOD at that meeting. (MSS Sub Res 4, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Sunset, This practice is out of date current MSS IOPs
107	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. (MSS Res 9, I-13)	Retain - Policy is still relevant
108	655.022MSS	MD/PhD AMA Membership: AMA-MSS will develop a mechanism for MD/PhD students and other students require greater than a 4 year training period to sign up for a longer AMA-MSS membership and make this available on the world wide web. (MSS Amended Res 15, I-98)	Retain - Policy is still relevant

		(Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	
109	660.001MSS	Questions of Parliamentary Procedures: (1) The AMA-MSS parliamentarian will be either the Speaker or Vice Speaker, whoever is not presiding over the Assembly. (2) The AMA-MSS Governing Council will appoint a temporary parliamentarian when either the Speaker or Vice Speaker is not present. (MSS Sub Res 5, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)	Retain - Policy is still relevant
110	145.012MSS	Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks: AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks. (MSS Res 15, A-13)	Retain - Policy is still relevant

111	145.013MSS	Strengthening our Gun Policies on Background Checks and the Mentally Ill: AMA-MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13)	Retain - Policy is still relevant
112	160.026MSS	Public Reporting of Physician Outcomes: AMA-MSS supports that all programs that publicly report physician outcomes consider a petition process that allows healthcare providers to request exceptions for extreme risk unaccounted for by risk adjustment, and procedures performed for palliative purposes. (MSS Res 13, A-13)	Retain - Policy is still relevant
113	160.027MSS	Readability of Patient Materials: AMA-MSS supports health literacy such that patient materials be written at a level understandable by the patient population. (MSS Res 16, A-13)	Retain - Policy is still relevant

114	180.015MSS	Privacy Issues for Minors Regarding Insurance Company Explanations of Benefits: AMA-MSS will ask the AMA to (1) advocate for maintaining privacy regarding the doctor patient relationship for adults and dependents who are insured through their spouse, parent, or guardian, respectively; (2) advocate against allowing insurance companies to send Explanations of Benefits containing sensitive medical information regarding both adults and dependents to anyone other than the patient or their health care provider; and (3) advocate that Explanations of Benefits be made available only if an insurance claim has been denied, in which case the information should be sent directly to the (adult or dependent) patient, who may then choose to discuss it with their physician or share it with their spouse, parent, or guardian. (MSS Res 11, A-13) (AMA Res 801, I-13 Referred)	Retain - Policy is still relevant
115	245.019MSS	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	Retain - Policy is still relevant

		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])	
116	250.024MSS	Regulations in Times of Armed Conflict: AMA-MSS will ask the AMA to (1) endorse the World Medical Association's "Regulation in Times of Armed Conflict" as policy on the topic of medical neutrality; and (2) advocate that the United States use its voice in international affairs to protect medical neutrality. (MSS Res 22, A-13) (AMA Policy H-520.998 Reaffirmed in Lieu of AMA Res 601, I-13)	Retain - Policy is still relevant
117	270.026MSS	Strongly Advocate for Federal Funding for Indian Health Services: AMA-MSS (1) supports increased federal funding for Indian Health Service programs that directly influence medical student education opportunities; (2) supports AMA advocacy that all of the facilities that serve American Indian and Alaska Native populations under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; and (3) supports the AMA partnering with recognized American Indian health advocacy organizations like the National Indian Health Board, the National Congress of American Indians, and the Association of American Indian Physicians to advocate for increased funding for Indian Health Services in Congress. (MSS Res 27, A-13)	Retain - Policy is still relevant

118	295.174MSS	Evaluation of Standardized Clinical Skills Exams: AMA-MSS will ask the AMA to (1) evaluate the benefits and consequences of the implementation of the standardized clinical skills exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical Skills Exam and their implications for US medical students. (MSS Res 7, A-13) (AMA Res 904, I-13 Adopted [D-295.960])	Retain - Policy is still relevant
119	305.078MSS	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)	Retain - Policy is still relevant
120	310.048MSS	Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies: AMA-MSS supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning,	Retain - Policy is still relevant

		and counseling for unintended pregnancy. (Late Res 2, A-13)	
121	310.049MSS	Equal Paternal and Maternal Leave for Medical Residents: That our AMA amend policy H-405.960 by insertion and deletion as follows: H-405.960 Policies for Maternity, Family and Medical Necessity Leave AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement; (2) Recommended components of maternity and paternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave	Retain- Policy is still relevant

		credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption~~; and (j) leave policy for paternity~~. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity and paternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into	

		their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man should be required to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term	

		personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in	

		identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity and paternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year; and (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (CCB/CLRPD Rep. 4, A-13) (Modified: Res. 305, A-14) (MSS Res 36, A-14) (AMA Res 904, I-14 Adopted as Amended)	

122	315.003MSS	Enabling a Contiguous, National Electronic Health Record Network: AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13)	Retain - Policy is still relevant
123	370.012MSS	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)	Sunset, Policy Accomplished
125	490.024MSS	Banning Smoking While Driving in Vehicles in which Minors are Present: AMA-MSS will ask the AMA to support legislation that prohibits smoking while operating or riding in a vehicle that contains children. (MSS Res 25, A-13)	Sunset, Policy Accomplished

126	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~~	Modify and Retain- Policy is still relevant, but requires updates to better reflect current IOPs, process updates per RTF recommendation, and technological changes.

		~~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.~~ AMA Website. 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.~~ (Amended GC Rep A, A-13)	

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REPORT OF THE MEDICAL STUDENT SECTION
GOVERNING COUNCIL

GC Report B, I-18

Subject:	Pilot Implementation of the 2018 Resolution Task Force Recommendations Update
Presented by:	Karen Dionesotes, Chair
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

INTRODUCTION

After the 2017 Interim Meeting of the American Medical Association Medical Student Section (AMA-MSS), the AMA-MSS Governing Council (GC) convened a MSS Resolution Process Task Force (RTF) to make recommendations to strengthen the MSS resolution review process. The RTF was asked to address concerns about the functionality and capacity of the existing process, including:

A. Insufficient time for adequate discussion of resolutions in the Assembly
B. Impact on student leadership (including sectional and regional delegates as well as the MSS House of Delegates Coordinating Committee)
C. Impact on AMA staff (including MSS staff and non-MSS experts)
D. Number of external resolutions forwarded to House of Delegates (HOD)

The RTF produced MSS RTF Report 1-A-18, containing 24 resolution process reform recommendations to encourage mentorship within the MSS, protect the democratic opportunity to be heard, foster high-quality discussion in the MSS Assembly, and preserve resources for the advocacy of MSS-originated resolutions in the AMA HOD. The GC amended these recommendations in MSS GC Report A-A-18 and proposed a pilot year where implementation would begin during the next cycle of the resolution process, I-18, followed by a GC Report to the Assembly at the 2019 Annual Meeting. The MSS Assembly adopted GC Report A-A-18 with the exception of Recommendation 8(b).

STATUS OF PILOT IMPLEMENTATION FOR I-18

The GC has implemented the majority of the GC Report A-A-18 recommendations in the first stage of the pilot year. This report serves as a brief update on the implementation status for each recommendation; the GC will provide a detailed report on the results of implementation at A-19 and make recommendations for the resolution process moving forward. Any interested

party may consult the GC about the pilot implementation at any time by contacting the MSS Section Delegates.

Table 1. Implementation Status

Rec.	*Summary*	*Status*
1a	Training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.	Collected survey information. Will implement for newly elected RDs at I-18.
1b	Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made.	Filmed at I-18
2a	Clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals.	Active GC discussion with concurrent updates.
2b	Creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting.	Completed at I-18.
2c	Providing a formal document to its members as proof of significant, non-resolution-related work.	Completed at I-18. Document available on request.
3a	Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author.	Completed at I-18. Manual option used for I-18, may advance option at A-19.
3b	Requiring all external resolution authors to contact the relevant specialty society prior to submission.	Completed at I-18.
4a	Tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing.	Completed at I-18.
4b	Broadening the functional scope of the HCC so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.	Completed at I-18.
4c	Requiring primary reviewers to send feedback summary emails to the primary author's Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.	Not completed at I-18. To be completed at A-19.
4d	Requesting that HCC post a summary of their comments from the draft review process to the VRC.	Completed at I-18.

4e	Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations were not considered.	Completed at I-18.
5a	Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.	Centralized process initiated at I-18. Will be improved for A-19.
5b	Giving the HOD Coordination Committee responsibility to review all submissions and place items on a Reaffirmation Consent Calendar.	Completed at I-18.
5c	Adjusting resolution deadlines to allow more time for review between the final submission and VRC.	Completed at I-18.
6a	Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, relevance to the MSS Policy Objectives, thoughtful response to feedback, and quantitative scale scoring.	Completed at I-18.
6b	For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas.	Completed at I-18.
6c	Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category.	Completed at I-18.
7	That the MSS reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores.	Completed at I-18.
8a	The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action item.	Completed at I-18.
9a	Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD, if their resolution is passed by the Assembly.	Completed at I-18.
9b	Tracking the outcome of MSS-initiated external resolutions that have had influence or impact.	Report to be published at A-19.
9c	Giving the MSS GC responsibility for conducting an annual survey that sets the MSS Policy Objectives for the given year.	Active GC discussion with survey planned for distribution at I-18.

CONCLUSION

Your Governing Council has made significant strides toward implementing the recommendations adopted from GC Report A-A-18 throughout the resolution review process for

I-18. A few recommendations remain to be implemented, notably improvements to the GC Action Item process and prominence and distributing a survey that will set MSS Internal Policy Objectives. Your GC will also continue to improve on the recommendations that have been implemented at I-18. A detailed report of the pilot implementation will be forthcoming at A-19 with recommendations to formalize successful changes to the resolution process for the future. Comments, concerns, and questions from members are always welcome as your GC continues working to improve our MSS resolution review process.

APPENDIX A. GC Report A-A-18

REPORT OF THE MSS GOVERNING COUNCIL

GC Report A-A-18

Subject: Pilot Implementation of the 2018 Resolution Task Force Recommendations

Presented by: MSS Governing Council
(Helene Nepomuceno, Chair)

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

INTRODUCTION

After the 2017 Interim Meeting of the American Medical Association Medical Student Section (AMA-MSS), the AMA-MSS Governing Council (GC) convened a MSS Resolution Process Task Force to make recommendations to strengthen the current resolution process.
The charge to the MSS Resolution Process Task Force (RTF) was to assess the effectiveness of our current resolution process in achieving its goals, to collect and evaluate information on the impact of our current process on the various stakeholders in our process, and to recommend actions and efforts that would have a meaningful positive impact on the major resolution process concerns:

a. Insufficient time for adequate discussion of resolutions in the Assembly
b. Impact on student leadership (including sectional and regional delegates as well as the MSS House of Delegates Coordinating Committee)
c. Impact on AMA staff (including MSS staff and non-MSS experts)
d. Number of external resolutions forwarded to House of Delegates (HOD)

The RTF produced MSS RTF Report 1-A-18, containing recommendations for resolution process reforms that the RTF believes will encourage mentorship within the MSS, protect the democratic opportunity to be heard, foster high-quality discussion in the MSS Assembly, and preserve resources for the advocacy of MSS-originated resolutions in the AMA House of Delegates (HOD). The RTF recommended that the MSS GC consider its proposed reforms to the resolution process and release a GC Report to the Assembly detailing a pilot implementation of the reforms.

The MSS GC conducted a review of recommendations proposed by the RTF within MSS RTF Report 1-A-18. Based on the Task Force's recommendations, the MSS GC has outlined in this report a pilot process to be implemented during the next cycle of the resolution process for the 2018 MSS Interim Meeting and HOD Interim Meeting.

PILOT RESOLUTION PROCESS

Your GC recommends the implementation of a pilot based on the following reforms during the next cycle of the resolution process, and that the remainder of the report be filed. Following the pilot, the MSS GC will produce a GC report to the Assembly for the 2019 Annual Meeting

proposing changes to the MSS resolution process through amendments to the MSS Internal Operating Procedures.

1. That the MSS invest in further education efforts on the resolution process by:
    a. Training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS.
    b. Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made.

2. That the MSS elevate the stature of non-resolution avenues for advocacy by:
    a. Clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals.
    b. Creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair.
    c. Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee.

3. That the MSS encourage mentorship between its members and throughout the AMA by:
    a. Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process.
    b. Requiring all external resolution authors to contact the relevant specialty society prior to submission.

4. That the MSS improve transparency of resolution feedback among all actors throughout the resolution process by:
    a. Tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office.
    b. Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed.
    c. Requiring primary reviewers to send feedback summary emails to the primary author's Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to.
    d. Requesting that HCC post a summary of their comments from the draft review process to the VRC.
    e. Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered.

5. That the MSS streamline existing procedures in the resolution process by:

a. Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached.
b. Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent Calendar will not receive detailed staff review except analysis from Legal Counsel.
c. Adjusting resolution deadlines to allow more time for review between the final submission and VRC.

6. That the MSS change its scoring rubric to:
    a. Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale.
    b. For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives.
    c. Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category.

7. That the MSS reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores.

8. That the MSS create and further opportunities for high-quality discussion in the Assembly by:
    a. The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action item. GC Action items may be submitted by the originating author or by individual members of the Section.
    b. Prioritizing Assembly time so that resolutions above a certain threshold receive protected time for debate, with the remaining time divided between resolutions below the threshold. Determination of this threshold shall be based on consideration of the amount of time needed to discuss a resolution and the amount of Assembly time available. To aid in this determination for I-18, GC will collect data at A-18 on how much time is spent discussing each resolution.

9. That the MSS improve continuity of its advocacy efforts from meeting to meeting by:
    a. Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly.
    b. Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership.
    c. Giving the MSS GC responsibility for conducting an annual survey that sets the MSS Policy Objectives for the given year.

REPORT OF THE AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION COMMITTEE ON MEDICAL EDUCATION

MSS CME Report A
I-18

Subject: Requiring Blinded Review of Medical Student Performance

Presented by: MSS Committee on Medical Education
James Docherty, Chair; Stephanie Strohbeen, Vice Chair

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At its 2017 Interim Meeting, the AMA-MSS Assembly referred for study MSS Resolution 93, "Requiring Blinded Review of Medical Student Performance," which states the following:

> 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.

Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Medical Education (CME). Your CME performed an analysis of pertinent policies on review boards so that the MSS could account for a broad scope of medical schools and acknowledge varied perspectives, including those outside of the AMA-MSS. This report begins with an overview of professionalism and academic performance assessments. It then examines the resolved clauses of Resolution 93, I-17 and discusses pertinent implications for each of these recommendations. Each section contains a summary that recapitulates CME's reasoning for supporting or not supporting the proposals in Resolution 93. Your CME provides its own amendments to Resolution 93. The primary goal of which is to emphasize fair evaluation of medical students, which is reflected in the Recommendations portion of this report.

BACKGROUND

i. An overview of medical professionalism and the assessment thereof

Medical professionalism is a core component in patient care. It's been shown to have high association with improvements in physician-patient relationships, patient satisfaction, health care professionals' career satisfaction, and even healthcare outcomes.[1–5] Tools to assess

professionalism in the medical field started developing thirty years ago and in 1986 the Liaison Committee on Medical Education (LCME) created a requirement for more allopathic medical schools to include professionalism training in the curriculum.[1,6]

Professionalism is taught throughout undergraduate medical education (UME), classically in didactic and simulated scenarios during the first two years of medical school and through clerkship experiences during third and fourth years of medical school. There is no one standardized method for teaching the complex and evolving topic of medical education.[6]

Many different instruments have been developed to assess medical professionalism, with no clear method being the most superior. However, assessment tools incorporating student feedback have shown to be more effective in evaluating the student's professionalism as well as the student experience (such as clerkship rotations).[1,6]

The LCME states in their "Standards for Accreditation" that all allopathic schools must have a variety of measures employed, one of which is **direct observation** to assess student achievements in learning, such as behaviors/professionalism. Furthermore, all interactions between medical students and patients must be under supervision. They also instruct schools to create a system to receive feedback from students and a reporting system for student mistreatment and appeals. Lastly, no school can function in any capacity in a discriminatory manner.[7]

The Commission on Osteopathic College Accreditation (COCA) states similar requirements for osteopathic medical schools in regards to direct student observation, supervision, reporting systems for mistreatment and appeals, and creating a health learning environment.[8]

ii. AMA's Stance on professionalism training and assessment in UME

Our AMA House of Delegates has passed several resolutions regarding medical student professionalism over the years: H-295.886, D-295.984, H-295.995, H-295.900.

Briefly, the above policies will be discussed:

Policy H-295.886 asks our AMA to support regular assessments of student professionalism throughout UME to the purpose of creating valuable feedback and improving the students' performance in future assessments.

Policy D-295.984 encourages the sharing of professionalism learning and assessment tools between medical schools. It also asks our AMA to work with relevant stakeholders to collect this information and disseminate it.

Policy H-295.955 introduces a Code of Behavior covering the teacher-learner relationship and possible destructive characterizes to avoid and urges medical schools to follow. It also recommends medical schools "delineate procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, and (d) sanctions."

Policy H-295.900 addressed an effective and safe learning environment for teachers and medical students. It also takes measures to protect students who report incidents of mistreatment.

DISCUSSION OF PROPOSED RESOLVED CLAUSES BY MSS RESOLUTION 93, I-17

1. *Adopt with amendment by deletion and addition of the first proposed resolved clause to read as follows*

> RESOLVED, That our AMA ~~advocate~~ work with appropriate stakeholders, such as the LCME and the COCA, to support: (1) increased diversity and implementation of implicit bias training to faculty responsible for assessing medical students performance, such as measuring professionalism; (2) increased diversity and implementation of implicit bias training in any group of faculty (counsel, panel, board, etc.) responsible for investigating and ruling upon disciplinary matters involving medical students. ~~that all reviews of medical student professionalism and academic performance be conducted in a blinded manner; and be it further~~

Standards are set forth by the LCME and the COCA and must be followed by all medical schools in the United States to have full accreditation. Both organizations state direct observation is needed for assessment of medical students. Additionally, both sets of standards require supervision of medical students during interactions with patients. Clinical experience and assessments are imperative for medical student training and improvement and will continue being a core of UME. Failure to comply with the appropriate standards would result in a school's de-accreditation and risk the future career of the attending students.[7,8]

Feasibility of properly blinding all evaluations of medical students is difficult. Doing so implies hiding the identity of a medical student while under direct observation for assessment and supervision during patient contact. Currently there is no literature investigating the impact of blinded evaluation of medical student professionalism or unsupervised patient care via student.

Increasing diversity of those that evaluate medical students can alleviate any discriminatory (conscious or unconscious) that may occur during these assessments. Implicit bias or discriminatory training also hold the potential to improve evaluations.[9–14]

SUMMARY

Thus, to stay within long-standing accrediting agencies standards and to avoid patient harm, your CME recommends non-blinded evaluation when complying with accreditation standards, but with increased diversity to faculty and training for faculty to decrease any existent discriminatory behavior.

2. *Do not adopt the second proposed resolved clause*

Your CME believes language incorporated into the first resolved clause adequately covers communication with the LCME.

RECOMMENDATIONS

1) That the AMA-MSS formally support H-350.974, “Racial and Ethnic Disparities in Health Care”, noting the fourth clause:

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

    2. The AMA emphasizes three approaches that it believes should be given high priority:
        A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
        B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
        C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

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

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

2) That the AMA-MSS formally support D-295.983, “Fostering Professionalism During Medical School and residency Training

(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 foster the development of professionalism.

3) That the remainder of this report be filed.

ACKNOWLEDGEMENTS

This report was assembled by members of the 2018-19 AMA-MSS Committee on Medical Education (Nikita Agarwal, Ashleigh Bull, Joseph Camarano, Jarret Campbell, Marcus Fearing, Nicholas Haberli, Ayesha Kar, Christopher Mazis, Elizabeth Southworth).

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REPORT OF THE AMERICAN MEDICAL ASSOCATION MEDICAL STUDENT SECTION
COMMITTEE ON LGBTQ+ ISSUES

LBGTQ+ Report A, I-18

Subject: Gender and LGBTQ+ Discrimination in Income

Presented by: MSS Committee on LGBTQ+ Issues

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At the 2017 Interim meeting, the AMA-MSS referred MSS Resolution 88- "Gender and LGBTQ+ Discrimination in Income" which states the following:

RESOLVED, That our AMA amend D-200.981 by addition as follows:

D-200.981 Gender Disparities in Physician Income and Advancement:

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 nonacademic 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.

The resolution was referred due to the broad range of implications and severity of the issues. As such, the MSS Committee on LGBTQ+ and MSS Minority Issues Committee identified the following points adequately satisfies the purpose of referral:

(1) Potential outcomes of this amended, both positive and negative
(2) Determining if current policy adequately satisfies the asks of the resolution

(3) Potential alternatives to the resolution that would have significantly improved outcomes.

INTRODUCTION

Potential Positive Outcomes of Amendment

Recent reports suggest not only increased rates of poverty among LGBTQ+ individuals but also the presence of a pay gap faced by sexual and gender minorities individuals compared to the general population [1]. While 9% of the general population of working-age Americans were unemployed between March and October 2017, 13% of LGBTQ+ Americans were unemployed in this same time frame. Among trans and nonbinary Americans, the rate was 16%. [2] Furthermore, groups with intersectional minority identities face additional pay discrepancies. For example, women in same-sex couples have a median personal income of $38,000 compared to $47,000 for men in same-sex couples [3]. The spirit of the resolution is certainly in line with the goals of the AMA and other physician advocacy organizations to advance the health and well-being of traditionally marginalized groups. A recent report by the Williams Institute examined the potential outcomes if the so-called “sexual orientation poverty gap” were filled. That is, they looked at the outcomes of eliminating wage differentials across race, ethnicity, and sexual orientation and subsequently providing the people in the lower paid group the returns on their labor that they would be given in a higher paid group. They found that, if they closed the wage differential for same-sex couples compared to opposite-sex couples, the poverty rate in same-sex couples dropped from 5.6% to 5.1% and the poverty rate for different-sex couples also dropped from 6.6% to 5.8%. Furthermore, if they theoretically gave women the same returns men receive, the poverty rates for both same-sex and opposite-sex couples call again, but by a larger amount for same-sex couples (4.3%, and 5.7% for opposite-sex couples). [4] As such, this resolution brings up an important issue that could certainly impact the poverty rate in sexual and gender minorities. Since poverty has been linked with poorer health outcomes, the primary outcome of the proposed amendment would be the improvement of health and well-being of LGBTQ+ individuals.

Potential Negative Outcomes of Amendment

There are no notable negative consequences to advocating to close the wage gap – the primary limitation with the proposed amendment is the overlap with existing policy, discussed below. An additional limitation would be the enforcement of a policy addressing wage gap. Congress has passed ENDA, the Employment Non-Discrimination Act, which was intended to end workplace discrimination in hiring LGBTQ+ individuals, but it has not passed the Paycheck Fairness Act, which was intended to close the gender wage gap by increasing transparency in payment to discourage employers from sex-based pay discrimination [5,6]. While not necessarily a negative

effect of the proposed amendment, this issue calls into question the limitations in implementation of such a policy.

CURRENT POLICY

Existing policy D-200.981, “Gender Disparities in physician Income and Advancement” which states:

> 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

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already extensively addresses issues related to the gender wage gap, but it does not address wage discrimination issues specific to sexual orientation/gender identity. Data specific to a wage gap between LGBTQ+ physicians and non-LGBTQ+ physicians are not available. However, as stated above and in numerous reports, the issue of the sexual orientation/gender identity wage gap in the general population is well established. The authors of the proposed amendment, in this sense, are proposing new policy. The issue, however, is the lack of objective data to support the presence of a wage gap among physicians based on sexual orientation. Further, addition of the LGBTQ+ specific policy to the existing policy D-200.981 confuses the issues of gender wage discrimination faced by women and wage discrimination faced by sexual and gender minorities. As such, the report writers would suggest the authors propose a new policy within a more appropriate scope and with WHEREAS clauses that support the issue of LGBTQ+ wage discrimination, as the current resolution mostly discusses gender discrimination which is already addressed in D-200.981.

POTENTIAL ALTERNATIVES

Alternatives to the proposed amendment would be to further research the issue of wage gaps in medicine that are based on sexual orientation and gender identity. Some studies suggest that

physicians from gender/sexual minorities are less likely to pursue competitive/high-paying specialties, but the causality is multi-factorial and does not necessarily establish a wage gap as much as it simply suggests certain medical specialties are perceived as more friendly to sexual/gender minorities than others [3]. As such, we would recommend further research into this issue prior to adopting the proposed amendment.

As stated above, an additional alternative would be to separate out the issue of sexual orientation wage discrimination from gender based discrimination, as while the two issues intersect the resolution as written does not establish the importance of the latter within the medical profession. Studies suggest it is certainly an issue that could be addressed at the policy level, but clarifying the scope of the resolution and also expanding the amendment to include non-physicians or proposing a different resolution rather than an amendment may be an appropriate course.

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REPORT OF THE AMERICAN MEDICAL ASSOCATION MEDICAL STUDENT SECTION GOVERNING COUNCIL

LBGTQ+ and MIC Report A, I-18

Subject: Recognizing LGBTQ+ Individuals as Underrepresented in Medicine

Presented by: MSS Minority Affairs Committee, MSS Committee on LGBTQ+ Issues

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At the 2017 Interim meeting, the AMA-MSS referred MSS Resolution 30- "Recognizing LGBT Individuals as Underrepresented in Medicine" which states the following:

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.

The resolution was referred due to the broad range of implications. As such, the MSS Committee on LGBTQ+ and MSS Minority Issues Committee identified the following points adequately satisfies the purpose of referral:

(1) Clarify all potential consequences (both positive and negative) of the inclusion of the LGBTQ community as underrepresented in medicine

(2) Recommend solutions to noted consequences of considering the LGBTQ community underrepresented in medicine

(3) Recommend solutions to the LGBTQ community's underrepresentation in medicine alternative to the formal recognition as 'underrepresented in medicine.

POTENTIAL CONSEQUENCES OF INCLUSION OF THE LGBTQ+ COMMUNITY AS UNDERREPRESENTED IN MEDICINE (URM)

Positive consequences

The potential positive consequences of a more inclusive definition of “underrepresented in medicine” have been noted in previous “Reports on Diversity and Inclusion” by the AAMC [1]. Several studies indicate patient-provider concordance have several beneficial consequences, including improved provider empathy, improved patient outcomes, and greater patient satisfaction and adherence [2][3]. Specifically, LGBTQ+ individuals have faced unique health disparities, including examples such as poorer access to health care services, increased rates of breast cancer in lesbian women, and increased discrimination by health care providers [4][5]. This history of health disparities led the NIH to designate LGBTQ+ individuals as a health disparities population for the purpose of scientific research [6]. Thus, representation of LGBTQ+ individuals in the medical field could help mitigate these health disparities.

Negative consequences

The theoretical consequence of including LGBTQ+ individuals in the definition of “underrepresented in medicine” is the exclusion of other groups that have also been traditionally considered underrepresented and marginalized in medicine. This potential consequence is important to note considering that, despite the URM designation based on ethnicity, the matriculation of students from URM backgrounds has not improved significantly in approximately the last decade. For instance, Black medical students still only comprise 5.8% of all graduated students on medical student exit surveys, compared to being more than 12% of the total US population. [7]. There are no studies to suggest that expanding the definition of URM has had any effect on recruitment of minority applicants and retention. This limitation is likely due to the fact that the goal of representation within medicine that is comparable to proportion of the population has never been achieved. However, there have been numerous reports of discrimination against Asian-Americans due to their status as “over-represented,” but none of these are related to LGBTQ+ representation.

In addition, if “underrepresented in medicine” is to remain a definition based on proportion of medical students/providers relative to the general population, LGBTQ+ individuals may not qualify. The number of LGBTQ+ individuals in medical school, however, was 4.7% as compared to 4.5% of the general population [8]. However, this data is only representative of those graduating from medical school and is not an estimate of LGBTQ+ physicians currently in practice.

Solutions to noted consequences

While LGBTQ+ individuals are not underrepresented in medical school by sheer number per the AAMC exit data, disaggregating the data to better ascertain the nuances and intersections of LGBTQ+ identity would provide more information prior to consideration for formal recognition. This would be beneficial because, within the LGBTQ+ community, transgender patients face different barriers than gay and bisexual men who have a relatively better economic standing. Health disparities are also further propagated by intersections with low socioeconomic status and ethnic minority status. It may also be appropriate to encourage the AAMC to include questions not only about LGBTQ+ identity of exit surveys, but questions about whether

LGBTQ+ individuals feel they can be open about their identity without fear of discrimination at their institutions.

ALTERNATIVES TO FORMAL RECOGNITION AS “UNDERREPRESENTED IN MEDICINE”

As previously stated, LGBTQ+ health disparities and discrimination by healthcare providers are a significant issue in our society and social identity concordance with a provider as well as physicians having more LGBTQ+ colleagues can be a step to help decrease these health disparities and discrimination. Thus, it can still be possible to encourage medical schools to be more vigilant about LGBTQ+ recruitment into their schools for the states reasons above regardless of whether sexual identities are currently incorporated in the definition of a URM or that the estimated population of LGBTQ+ individuals in medical schools is similar to the general population.

Beyond recruitment, it is also imperative to ensure medical schools are intentional and vigilant in creating an environment that is welcoming to those who openly identify as LGBTQ+. Someone may be willing to answer their sexual orientation on a survey, but whether that translates to those individuals feeling comfortable at their schools to be open about their identity is unknown by the AAMC survey alone. Thus, regardless of URM status, medical schools should still be aware of the potential discrimination that these students may face and have policies to protect these individuals.

CONCLUSION

The spirit of Resolution 30 is certainly positive in attempting to bring about change to alleviate health disparities faced by LGBTQ+ individuals, but at this point there is insufficient evidence to alter the definition of “underrepresented in medicine” given that this has been historically based on ethnic background, and current AAMC exit surveys show similar percentage of LGBTQ+ individuals in medical school as in the general population. A good next step would be moving to disaggregate data of LGBTQ+ individuals in medicine to better understand how many students identify within the different subsets of the LGBTQ+ community and how much their LGBTQ+ identity intersects with status as an ethnic minority, low SES, etc. Lastly, regardless of URM classification, we encourage medical schools to take steps to be inclusive environments for LGBTQ+ students to be open about their identity and be cognizant of the discrimination that these students and LGBTQ+ patients may face in the healthcare system.

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REPORT OF THE AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

MSS CHIT REPORT
I-18

Subject: Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication

Presented by: MSS Committee on Health Information Technology;
Neel R. Nabar (Chair), Baillie Bronner (Vice Chair), Alex Paschke, Brian Ayers, Samuel Roberts, and Ian Shields

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At the 2017 Interim meeting, the AMA-MSS referred the MSS resolution 71- “Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication” which states the following:

> 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.

Accordingly, your Governing Council (GC) referred this report to your MSS Committee on Health Information Technologies (CHIT). Your CHIT studied the state of development of APIs and the existing ecosystem of open application marketplaces as they relate to EHRs. We examined the roles of various public and private sector players in shaping the landscape governing API implementation and open application marketplace adoption, and looked into existing AMA initiatives already addressing the spirit of this resolution. Finally, your CHIT performed a detailed analysis of existing AMA policy on EHR interoperability and National Health Information Technology in order to determine if additional, more specific policy is needed to address this particular issue. This report begins with pertinent background information on open application marketplaces and APIs in an effort to educate members of the assembly on these technical issues. We discuss advantages and potential drawbacks of these technologies

and the big picture health information technology (HIT) problems they aim to solve. We discuss the role of the public sector Office of the National Coordinator of Health IT (ONC) and the AMA-private sector joint Integrated Health Model Initiative (IHMI) in solving these large scale HIT issues. Finally, we discuss existing relevant AMA policy on these important HIT issues and provide our recommendations on the resolved clauses at hand.

BACKGROUND

Issues with HIT have contributed to high levels of physician burnout and dissatisfaction while impeding the patient-physician relationship. EHRs specifically play a major role in physician dissatisfaction, and current systems have numerous issues regarding interoperability, data portability, and adaptability that negatively impact the end-user experience. [1-3] Limitations related to data portability and interoperability are complex, as apart from technological considerations, competing interests and misaligned incentives are roadblocks limiting full interoperability. [4] Only an integrated approach with cooperation among a variety of stakeholders (including governmental, EHR vendors, and providers) will result in true EHR interoperability. Enhancing EHR functionality presents a different set of challenges. Upgrading or switching EHR systems is challenging for providers due to the high implementation costs and difficulty associated with EHR training. [5] As a solution, third-party applications have been developed to enhance EHR functionality, but survey data suggests that small companies report difficulty integrating their products with larger EHRs, in part because some EHR vendors were unsupportive of such integration efforts. [6] Despite the challenges facing physicians regarding EHR use, recent survey data shows that physicians overwhelmingly see the potential for digital health to favorably impact patient care (85%) and are optimistic about the potential for improving practice efficiencies and reducing burnout. [7] Among the reasons physicians remain optimistic about digital health are that it offers innovative solutions to current EHR problems through features like Application Programming Interfaces (APIs) and open application marketplaces. These solutions are introduced below.

Application Programming Interfaces

APIs provide the infrastructure to facilitate communication between software programs. The use of APIs allows data to be transferred outside the application in which it originated. A popular example outside the healthcare industry is the use of web-based ticket pricing applications. Prior to the use of APIs, customers would need to search airlines individually to find the flight that fit their scheduling and pricing needs. Today, sites can aggregate that information using APIs provided by airline carriers to offer a convenient tool to passengers. [8]

Healthcare APIs seek to accomplish much the same goals in terms of improving usability and encouraging data portability. The ONC has previously identified APIs as candidates to transform the healthcare industry and issued certification criteria to ensure a level of consistency and security across EHRs. [8] Of note are those APIs designated as “standardized” and “open.”

Standardization is recommended by ONC certification material but is not required; thus EHRs may implement their own structure and format needed to access a piece of data. Third-party application developers would need to conform to those specifications if they wanted their application to work on that brand of EHR. The “openness” of an API refers to the ease with which the information about an API is accessible. Open APIs are also recommended, but not required for ONC certification at this time. [9] The 21st Century Cures Act (CCA) has also identified API-enabled data sharing as integral to the ongoing use of EHRs in a modern healthcare setting. [10] Moreover, stage 3 of the meaningful use EHR incentive program from the CMS and ONC includes an API requirement. [11]

There are multiple emerging standards that may fulfill these recommendations; of note, the Fast Health Interoperability Resources (FHIR) standard has gained traction. Many popular EHRs partially support this standard. [9] What partial support means in practice is that some pieces of data, e.g. blood pressure cuff readings, could be accessed according to FHIR guidelines, while other data, e.g. automated cardiac monitor readings, may require a separate configuration to access proprietary API standards. Note, these are meant to be illustrative and not referential to any current EHR software. In sum, integration of standard APIs into health information systems provides a technological solution aimed at solving the critical issues of interoperability and data portability, and it can facilitate development of third-party add-ons to traditional EHRs.

Open Application Marketplaces for EHRs

The modern EHR ecosystem has matured dramatically since the 2009 passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Almost 100% of US hospitals and more than 75% of physician practices report the use of an EHR certified by the Department of Health and Human Services as offering functionality adhering to national technology standards. [12] In response to the surge in provider use, EHR vendors have expanded service offerings well beyond the initial certification criteria. The breadth of products incentivizes one-provider-one-system architectures by promising unimpeded data flow across clinical services (e.g. between ambulatory care products and specialty provider products). While this may provide temporary relief to the growing pains of new EHRs, ultimately there are still elements of user dissatisfaction with the complexity and efficiency of these tools. [13, 14] This state of mismatch between requirements and solutions highlights the pain points that emerging technologies may help alleviate.

One approach vendors have developed to address variability across provider workflows is the implementation of application marketplaces. The majority of these are generally analogous to the “app stores” popularized by Apple Inc. iOS and Google LLC Android smartphone platforms. Third-party (i.e. neither the software company nor the customer) developers are granted access to user data for use in their application which generally extends the platform functionality. [15] The traditional “closed” marketplaces described above force compliance to any specificities unique to that EHR platform, e.g. all apps listed on the Epic Systems App Orchard are built specifically for one or more Epic EHR offerings. That same app may or may not function on the equivalent Cerner App Gallery or other EHR platforms. In practice we find a mixture of applications

redeveloped for multiple systems, apps that did not require redesign, and apps that are exclusive to one platform.

The ONC has previously found from the Health Information Exchange (HIE) Cooperative Agreement Program that technology creating potential barriers to data access are among the key challenges to recognizing the systemic benefits of EHR interoperability. [16] Alternative marketplace models have subsequently opened with interoperability in mind. One example of an "open" application marketplace is the Substitutable Medical Apps Reusable Technologies (SMART) on FHIR initiative. The core difference from traditional proprietary marketplaces is moving compatibility one rung above the EHR platform. In this paradigm, the EHR vendor and the third party developer ensure compatibility with the SMART on FHIR web application, which enforces the FHIR standards. [17] It is one of several projects seeking to realize the ONC directives on interoperability in healthcare by using open, standards-based APIs. SMART on FHIR offers a user-friendly app gallery feature to encourage providers to browse potential features to add to an existing EHR solution without compromising compatibility. In this way, open application marketplaces use APIs to promote interoperability and enhance EHR functionality. Together, APIs and open application marketplaces aim to enhance data portability, interoperability, and EHR functionality.

AMA EFFORTS PROMOTING DATA PORTABILITY AND EHR FUNCTIONALITY

Integrated Health Model Initiative (IHMI)

The Integrated Health Model Initiative (IHMI) is an ongoing initiative organized by the AMA in partnership with a variety of industry partners. [18] Launched in October 2017, [19] the IHMI is an online platform designed to bring members of the healthcare and technology sectors together, forming a working community. By providing a digital area to share ideas and expertise, the goal of the IHMI is to increase collaboration between traditionally separate factions in the HIT sector. This collaborative effort is underway to pioneer a shared framework for organizing health data, emphasizing patient centric information and refining data elements to those most predictive of achieving better outcomes. Participation in the IHMI is open to all individuals interested in improving digital healthcare, including early partnerships with IBM, Cerner, Epic, and the American Heart Association.

The process to create this shared framework is organized around a continuous feedback loop on the online platform. [20] First, a group of healthcare providers form an online community on the platform to discuss costly or burdensome areas in their field that need improvement. Using their collective expertise, they identify best practices and specific data elements relevant to the health of their patient populations. Once a common model is agreed upon, it is sent to a peer review panel to evaluate the clinical applicability of the content submitted. If the expert panel agrees with the model, technology experts are engaged to configure and distribute the model for use nationally. The end result is a common data model customized for a given patient population that can be used across all electronic medical record systems. In the way that APIs are a programming oriented solution to data portability and interoperability, the IHMI is addressing this

issue from a data organization viewpoint in an effort to bootstrap industry partner development of data sharing technologies. The community also has an educational component and hosts forums allowing physicians to gain insight into the current landscape of data sharing, among other topics. In this way, the AMA is already addressing some of the goals of the resolved clauses of this report via the IHMI.

Office of the National Coordinator for Health Information Technology (ONC)

The ONC is the primary governmental entity overseeing nationwide efforts to implement and use the most advanced health information technology available. The ONC publishes a yearly Interoperability Standards Advisory, the latest of which included a section on APIs and provided fundamental principles relating to their development. [9] The ONC has also launched a voluntary Health IT Certification program, and in a previous statement the AMA committed to continue to work with the ONC (and CMS) to refine their policy on the use and implementation of certified health IT. [21]

RELEVANT EXISTING AMA POLICY

National Health Information Technology D-478.995

AMA Policy D-478.995, which was first passed as Res. 730 at I-04 after formation of the ONC and has been modified several times since:

> 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 continued 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, with physician input, 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.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

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; (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; (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care; and (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common

barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

DISCUSSION

At I-17, the authors of the original resolution believed that there was a lack of understanding on the issue by many giving testimony, resulting in referral for study. There are a variety of cogent arguments in support of these technologies. First, the authors argued that because large EHR companies are adopting FHIR as their API of choice and SMART as their standardization initiative, the AMA should form a direct stance on standard APIs and open application marketplaces. Your CHIT acknowledges the importance of technological standardization allowing interoperability and data portability, which are already recognized as key principles driving successful EHR development. It follows that application marketplaces could promote EHR functionality and usability, and the authors of the original resolution argue that specific policy may help lower overall costs accrued by providers trying to enhance EHR functionality. In support of open application marketplaces particularly, this approach may promote novel applications that are outside of the scope of the vendors themselves, as third-party participation in the market has the potential to drive innovation and increases EHR functionality.
The discussion related to open application marketplaces is more complex, and it is with this consideration we consider the negative possibilities as well. Application marketplaces may promote entrenchment in a particular system, as seen with the iOS (Apple, closed source)/Android (Google, open source) market divide in the mobile device economy. While marketplaces may provide distinct advantages for users, they may pose an inordinate challenge to smaller EHR vendors without the flexibility to invest in an API implementation. Additionally, third-party application verification by marketplace implementers (Apple, Google) has remained inconsistent and is a broadly unregulated space that has resulted in numerous security and privacy risks to users; the exposure of patients to such risks is of particular concern.
Finally, as mentioned above, the authors felt that there was a lack of understanding about standard APIs and open application marketplaces on the floor as well as in the general physician and medical student population. Testimony suggested that it may be useful to develop educational materials for the AMA and MSS about technological advances happening in EHRs.

Resolved Clause 1:

The first resolved clauses asks for the AMA to study and form specific recommendations on supporting EHR open application marketplaces and standard APIs. It reads as follows:

> RESOLVED, that our AMA research and form recommendations on supporting the adoption of open application markets within EHRs and standard Application Programming Interfaces (APIs)

At I-17, the Reference Committee received testimony in opposition of this resolution for reasons of potential redundancy and scope. Your CHIT recognizes that standard APIs provide a valid avenue promoting interoperability and data portability but note that the AMA already has extensive policy supporting development of interoperable HIT systems and a strong initiative (IHMI) already underway to tackle these issues. AMA Policy National Health Information Technology D-478.995 states that

> (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 and (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.

AMA Policy EHR Interoperability D 478.972 states that

> Our AMA (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care; and (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data.

We believe this existing policy extensively covers the principles APIs and open application marketplaces promote. Second, we note that APIs and open application marketplaces are specific technological solutions to existing issues, and that specific recommendations on technical avenues to promote interoperability and data portability may be outside the purview of the AMA. Finally, in the absence of an acute problem with the progression of interoperability standards or the EHR system marketplace, your CHIT has not identified specific value in creating new policy to promote the as-yet undeveloped and undefined area of open application marketplaces within EHRs.

Resolved Clause 2:

The second resolved clause, while somewhat unclear in its original form, asks for the development of best practices for providers that may be disseminated to health professionals, and also touches on moderating disruption, improving EHR satisfaction, and improving care, which requires a coordinated effort among EHR vendors and providers. It reads:

> 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.

While, your CHIT appreciates the value in best-practice recommendations and the essential need for medical professionals to be informed about ideal methods for implementing EHR and other technologies in practice, we are unsure if the AMA is the appropriate body to be creating such technical standards themselves. We believe the AMA Integrated Health Model Initiative (IHMI), notably receiving support from the American Medical Informatics Association, to be appropriately addressing physician outreach and education regarding technology expansion. We further point out that very little clinical data exists on the use of open application marketplaces in EHRs, thus development of best practices may not yet be appropriate, and any report generated may end up being a summary on existing APIs and application marketplaces.

Finally, AMA Policy National Health Information Technology D-478.995 states:

> 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.

Your CHIT believes this existing broad policy covers the principles open application marketplaces promote - supporting direct collaboration and engagement of EHR vendors to achieve data portability and improve EHR usability.

RECOMMENDATIONS

In lieu of MSS Resolution 71 – “Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication,” your CHIT recommends:

1. That the AMA-MSS reaffirm its support for AMA Policy National Health Information Technology D-478.995; and
2. That the AMA-MSS establish formal MSS support of AMA Policy EHR Interoperability D-478.972.

We recommend the remainder of the report be filed.

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REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON HEALTH INFORMATION TECHNOLOGY &
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CHIT AND CEQM REPORT
I-18

Subject: Blockchain in Healthcare: Industry challenges and opportunities for emerging decentralized technologies

Presented by: MSS Committee on Health Information Technology; MSS Committee on Economics and Quality in Medicine
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Referred to: MSS Reference Committee
(Lauren Engel, Chair)

INTRODUCTION

At the 2017 Interim meeting, the AMA-MSS adopted MSS Resolution 25- "Healthcare Applications for Blockchain Technology" which states the following:

> RESOLVED, AMA-MSS 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

Accordingly, the MSS Governing Council assigned this task to the Committee on Health Information Technology (CHIT) and the Committee on Economics and Quality in Medicine (CEQM). Your CHIT and CEQM (referred to herein as "the authors") studied the current state of blockchain technologies, with emphasis on technical advantages compared to contemporary approaches and structural differences that may enable disruption of the current health information technology (HIT) ecosystem. We then applied our understanding of the advantages and drawbacks of blockchain to identify its potential impacts on health care costs, claims adjudication, health information interoperability, and HIT security. Finally, we provide policy recommendations encouraging AMA involvement in the development of blockchain guidelines in an effort to ensure physician input into the standardization of this digital health tool that may one day impact physician practice. This report first describes fundamentals of blockchain technology, illustrating the advantages it holds over current approaches. We then move onto its potential role in promoting HIT interoperability, including the potential to allow a to shift from provider driven to patient driven interoperability. Next, we discuss security considerations relevant to this new technology, and its potential role in alleviating current issues with claims adjudication. Finally, after a discussion of its effects on health care costs, we suggest policy recommendations to be brought to the AMA House of Delegates.

BACKGROUND

Introduction to Blockchain technology

Blockchain is a distributed database that stores records of all transactions and digital events carried out by its participants. The distributed database is known as the public ledger, and individual records or events stored on this ledger are known as blocks. The entirety of the "public" ledger is hosted across all participants (nodes) rather than a central entity. [1] The elimination of a central entity may be advantageous, as it mitigates the risk created by a single point of failure. [2] When a new block is added, every node on the network processes the transaction independently in order to verify the transaction and come to a consensus. Once consensus has been established, the block is timestamped, linked to all preceding blocks with its own unique signature, and contains the cryptographically unique signature of the blocks preceding it. The block and its unique signature are then visible to participants of the blockchain, though its contents are heavily encrypted. [3] While the technical cryptographical details utilized by blockchain systems are out of the scope of this report, the most important feature of blockchain technology is its hash-based immutability. Once something has been added to the blockchain, it is permanently stored across all nodes. [4] In this way, blockchain functions as a decentralized, immutable ledger capable of storing data without the need for a central responsible entity (Figure 1). [5]

Without a central entity acting as an intermediary between participants, there arises the need for "trustless" exchange of goods and information. "Smart contracts," which are important components of blockchain based platforms like Ethereum, [6] is a term used to describe a conditional blockchain transaction. In a smart contract, a user may pre-define a set of criteria and the smart contract technology can verify the terms have been met by the person engaging the contract and allow contract execution. For example, if goods are received by individual X, then individual Y will receive the currency retained within the smart contract. In short, blockchain based smart contracts enable agreements between parties that are governed and enforced by computer code.

While blockchain is most commonly known for its association with bitcoin, an important distinction must be made between bitcoin and blockchain technology applicable in a healthcare setting. Bitcoin functions as a truly public ledger, where any individual has access to the chain. Permissioned or tiered blockchain networks allow greater flexibility by having tighter access controls around consensus mechanisms or by restricting read and write controls to specific groups. [7] In this way, blockchain based systems can incentive and enforce appropriate participation across a variety of stakeholders, which are essential principles in successful HIT. Furthermore, we emphasize that blockchain, like any other platform, is an architecture upon which other tools and highways can be built. With these principles in mind, we discuss the potential risks and benefits blockchain technology poses in the healthcare industry.

INTEROPERABILITY

Current state of interoperability in healthcare systems

The 21st Century Cares Act defines HIT interoperability as technology that "enables the secure change exchange of electronic health information with, and the use of electronic health information from, other health technology without special effort on part of the user." [8] Interoperability positively impacts health systems in a variety of ways; it increases operational efficiency, reduces clinical duplication/waste, and enhances clinical care by providing access to longitudinal data at the point of care. [7]

Challenges in healthcare interoperability stem from both technological and systematic issues. From a technology perspective, the root issue stems from differences in data input, storage, and retrieval between different Electronic Health Records (EHR) platforms. There has been a concerted effort, including through the AMA driven Integrated Health Model Initiative, [9] to develop data structures that promote data sharing. Additionally, there has been an emphasis on Application Programming Interfaces like the Fast Health Interoperability Resources (FHIR) to promote the standardized output of data from proprietary EHRs to facilitate transfer of data outside the application it originated. [8,10] However, a great deal of progress remains to be made prior to achieving full technological interoperability.

From a systems perspective, the current interoperability landscape is provider driven. Data is generated by the hospital, pharmacy, or private practice and stored on their internal electronic health record (EHR) system. [7] This data is often siloed within the system it was created, in part because vendors tend to create interoperability protocols that work only within their system and because data sharing between systems primarily occurs only if incentivized or governmentally mandated. [11] This results in patient data remaining scattered across a variety of systems. Data exchange between institutions is not only operationally challenging, but requires a great deal of administrative effort as data sharing agreements, governance rules, transactional/entity authentication, and data integrity surveillance via anomaly detection must take place before any data exchange may occur. [12] State-level health information exchanges (HIEs) have been implemented to address these issues, but little evidence exists regarding their effectiveness and ability to lower costs and improve clinical care. [13]

Potential role for blockchain in promoting interoperability

Importantly, blockchain technology will not serve a panacea for all interoperability problems facing our healthcare system. Technological Data structure and sharing standards are still be required to allow efficient data transfer between systems, [14] though the open source nature of certain blockchain technologies may make adoption of these principles simpler. [15] With regards to data sharing between organizations, blockchain may alleviate several pain points in the current process. For example, blockchain can assist in allowing multiple stakeholders to agree on the "true" state of data (immutable ledger), may help decrease administrative costs regarding authorization and claims adjudication, and can better help define data ownership and reduce unauthorized data use through less burdensome computer code created by smart contracts. [7,16]

An important distinction between potential blockchain models for interoperability lies within whether clinical health data is actually stored on the chain (similar to an EHR), or whether the chain contains an immutable reference to the clinical data that is stored off the chain (functionally similar to an HIE). Several blockchain based projects with functional platforms to store clinical data exist, including the Healthcare Data Gateway, [17] MediBlock, [18], and MedChain. [19] The Healthcare Data Gateway and MediBloc platforms are permissioned platforms that aim to aggregate patient health data and allow patients to share that data with appropriate stakeholders. MedChain, on the other hand, is a permissioned network that facilitates bidirectional medication data sharing between providers and patients, including hospitals, pharmacists, and patients. While the software platform behind the applications have been built out, they require robust testing in a clinical setting. Furthermore, scalability issues due to the sheer transactional volume of clinical data may impede large scale implementation of blockchains in which clinical data is stored on chain. [20] Finally, as hospital systems have invested significantly in the implementation of current EHR systems, the implementation costs for blockchain based clinical data storage may also prove a significant barrier to adoption. [21]

Platforms where blockchain technology serves to facilitate management or governance of shared data may have lower implementation barriers while effectively promoting interoperability across systems. [21] Zysnkind et al. details a decentralized platform in which the blockchain layer enforces stakeholder access, but refers to data stored off-chain rather than storing it. [22] Another project, FHIRChain, addresses interoperability by adhering to the Office of the National Coordinator for Health Information Technology (ONC) standards for sharing data via utilization of the HL7 FHIR platform. [14] As opposed to storing clinical data on the chain, FHIRChain stores metadata that refers to stored data; this innovation addresses scalability issues as exchange of metadata remains lightweight, decreases the potential for data compromise as data itself is not transferred from the initial system, allows for fine access control via a permissioned network, and can provide functional audit logs via data stored on the chain. [14] Nonetheless, further clinical validation is required in each of these cases to determine effectiveness, as seen with blockchain based EHRs above.

Finally, blockchain technology may facilitate a systematic change from provider based interoperability to patient based interoperability. In this model, patients take more ownership of their data, allowing personal health data aggregation across different systems and patient driven permissioned access to relevant stakeholders, ideally while maintaining privacy through blockchain based cryptographic means. [7] The advantage of utilizing a blockchain based technology in this model is that it enables the integration of patient generated data (e.g. mobile app data) into EHRs, thereby enabling more provider access to patient information at the point of care. [23] In sum, with appropriate mandated standards for blockchain technology, it has the potential to enhance data sharing and interoperability. Development of these standards and robust clinical testing however are still required before its true worth in interoperability can be established.

SECURITY

Blockchain for enhancing traditional security issues in healthcare

HIPAA defines three pillars to securing personal health information (PHI): Administrative, Physical, and Technical safeguards.[24] In considering the security advantages and risks of Blockchain technology compared to contemporary approaches, each pillar must be assessed under more precise definitions of security: Confidentiality and Unforgeability. *Confidentiality* is the principle that information stored on the blockchain is either inaccessible to nonpermitted users and/or that the stored information is insufficient to identify a patient. *Unforgeability*, means that the record cannot be falsified, nor changed in retrospect.[5]

In the current system, administrative and technical security features have been developed to ensure confidentiality and unforgeability. Certain approaches used today include the encryption of personal devices, unique keys for decryption or access, and decentralized backups in case of hardware failure. Administrative security today focuses on various access control models (e,g., credentialing and usernames/passwords) as well as permissioning systems (e,g., physician vs medical student access to view/modify certain PHI).[25] These functions will largely remain the same in blockchain systems. An additional area of functionality provided by blockchain technology is the utility of a network of multiple stakeholders (nodes) working together to maintain the authenticity and up-to-date nature of the chain. This network can be further used to ensure confidentiality of information by limiting which nodes (ie hospitals or providers) can add to the chain or even access it; theoretically even by patients themselves.[26] Unforgetability, also referred to as “immutability” in blockchain literature, is a robust feature and common selling point of the technology, though novel consensus mechanisms may be needed to process the high volume of clinical data.

One of today’s major vulnerabilities is exemplified by ransomware attacks where special software “worms” get onto the data servers, encrypt them, and hold the data for ransom money. The centralized and often single-copy storages of patient data make this a regular approach used by attackers, with many such cases per year.[27–29] The distributed design of blockchain fundamentally precludes such an attack. By extension, the distributed system and consensus mechanism allows a network not only to synchronize, but also to effectively police each other and single out malicious or compromised members. Certain security risks occur during health information exchange between systems, including issue related to data ownership, data transparency and auditability, and fine grained access. Blockchain based smart contracts mitigate risks related to data misuse by selectively sharing appropriate data, permissioned networks enable fine grained access autonomously, and transparency and auditability become intrinsically enhanced by due to blockchain’s immutability. [7]

Apart from security, privacy is critical to the storage and exchange of health data. While the public nature of blockchain may seem in direct opposition to the privacy needs of healthcare data, Zyskind et al. [22] describes a blockchain based storage scheme devised to protect personal data. In essence, clinical health data is stored off chain with on chain identifiers pointing to data

storage locations. All on chain data is encrypted prior to storage, thereby ensuring confidentiality. As opposed to simply having a blockchain based signing key, users on this blockchain have both an encryption key and signing key, which increases the difficulty of an adversary posing as a user. Moreover, a bad actor controlling a hashtable node remains unable to see raw data of other nodes, as the data is encrypted with keys no other node possesses. [22] This model highlights how blockchain technology can circumvent its public nature to ensure privacy of health data.

Blockchain for secure integration of Mobile Health data via the Internet of Things (IoT)

The IoT refers to the network of smart devices that can connect and communicate with each other.[30] As wearable and implantable devices acquire wireless capability and record patient metrics in real time, the natural extension is that they should report said metrics to the EHR and potentially autonomously adjust function parameters per preset algorithms (e,g., detection of atrial fibrillation triggering ventricular pacing). The IoT puts this functionality within short grasp of today.

There are a variety of security concerns regarding open communication between EHRs and mobile devices, as they introduce new points of entry that can be exploited by bad actors. Several case studies have shown that blockchain can mitigate risks related to mobile data communication with EHRs through the use of smart contracts. [23,31] First, Ji et al demonstrate a system allowing the sharing of important patient location data using order preserving encryption and merkle trees to design a multi-level sharing scheme that remains decentralized, verifiable, and confidential. Performance evaluation via real world testing has shown that this type of model can facilitate sharing of sensitive mobile data in a secure way. [31] Additionally, Ichikawa et al. describe a proof of concept case study showing successful, tamper free data transfer from mobile data tracking of patients having undergone cognitive behavioral therapy for sleep. [23] The advent of secure data sharing between mobile platforms via blockchain platforms has potential to achieve incorporation of patient generated data routinely into daily clinical decision making due to access at the point of care.

CLAIMS ADJUDICATION

How claims are processed

The process of claim adjudication begins with the patient and his or her health plan. The purpose of a health care claim is to connect the patient and provider with the third party that has contracted with the patient to conditionally reimburse the provider for services rendered. These conditions are detailed in the agreement between the patient and third party (usually a private health insurance company and/or government service) and include the copay, deductible, out-of-pocket maximum, and other factors, such as the diagnosis and services conducted for said diagnosis.

After the patient receives the care from the provider, the claim is delivered to the third party. The claim will include the patient's demographic information, identifying information for the hospital or practice in which the patient was treated, identifying information for the providing practitioner(s), and list of services with the appropriate diagnosis codes for each service, among others. The payer then ensures that the information provided coincides with the contract the patient has with the insurance company and the claim is adjudicated appropriately with the billable amount divided between patient and payer. If the practitioner or practice also has a contract with the third party payer (in-network), then the total billable amount may be adjusted as per the initial agreement. Afterwards, the hospital or practice will send a bill to the patient with the corresponding amount owed and the insurer will send an Explanation of Benefits (EOB) to the patient detailing how the claim was adjudicated.

Time scale for claim adjudication

The process of claim adjudication is lengthy and can span across months from when the patient initially received care. In 2011, 66 percent of claims were received by health plans within two weeks of the date of service, but 16 percent of electronic claims and 54% of paper claims were sent to payers more than 30 days after the day of care. 9% of all claims were received more than two months from the initial day of service.[32] The advent of electronic claims has revolutionized the time scale by which claims are processed, but this is still an area of significant inefficiency.

Why claims are denied

According to the America's Health Insurance Plans (AHIP), over 93% of electronic claims are submitted electronically, a major shift from just ten years ago, and yet still 10% of claims received by health plans contain errors.[33] When these errors are detected either manually or electronically by the insurer, the claim is denied and sent back to the provider with a denial of payment, before being corrected and reprocessed. This process of claim submission, adjudication, denial, and resending presents a significant area of inefficiency with associated administrative costs within medicine. According to the Advisory Board, claim denials have increased substantially over each of the past six years and hospitals wrote off 90% of denials as uncollectible.[34]

Claim denials occur due to either an error in the information provided to the third-party payer or an inconsistency in the claim that does not conform to the patient-payer and/or provider-payer contracts. Most providers now employ claim "scrubbing" software in order to oversee basic elements of the claim and ensure "clean" claims are sent out. While this does resolve some denials, even this software cannot address real-time updates based on the constant flux among patients, their demographic information, and their health insurances.

Fraudulent claim submission

The Federal Bureau of Investigation has estimated that fraudulent billing to public and private health care programs are between 3-10% of total health care expenditures.[35] In fact, in 2010, Medicare and Medicaid paid $68.3 billion in improper payments.[36] These costs contribute to both higher insurance premiums and less money available to those incurring legitimate medical expenses. Sources of such cases of fraud include withholding of diagnoses on a medical record, withholding information about multiple insurance coverage, filing claims on behalf of ineligible members, and submission of alternative diagnoses to ensure coverage by a specific insurance plan.

Potential for blockchain

Blockchain has a legitimate role in addressing the denials caused by inconsistent information and lack of real-time updates between patients, providers, and payers. Blockchain technology can enable multiple parties to share and add to data real-time in a distributed fashion, transparent to all three parties of the transaction. According to LexisNexis Risk Solutions, 2-2.5% of provider demographic data changes each month, and 35% of provider records have incorrect or missing information.[37] Real-time updates of provider information across all insurance networks would help minimize this cause of claim denials, with the only potential for error being incorrect initial input of data.

Perhaps the greatest potential for blockchain innovation is within the claims adjudication process itself. The current process of accepting or denying claims based on a patient's insurance policy is manual, and disputes in this process that reference long payer-patient and payer-provider contracts, with errors being made on the provider and payer sides. The utilization of a smart contract that resides on the blockchain network could entirely automate this process across organizations. Insurance policies for each individual would be captured within this smart contract and instantly applied to the services rendered and claim submitted.[38] Before the submission, the smart contract would allow verification of policies in concordance with the CPT codes for services in the medical chart and the patient responsibility of the claim can be collected in a timely manner.

Additionally, there is a potential use case for blockchain in the realm of detecting and inhibiting fraud. On-chain edits to patient demographics, medical history, and diagnosis and procedure entries are immediately available to all parties privy to the patient's medical record and are stored in the history of transactions on the blockchain. Immutability of previous entries increases transparency between patients, providers, and third-party payers.

Hao Wang and Yujiao Song detail a cloud-based and blockchain-based secure EHR that would allow a secure, yet transparent claims adjudication system (Figure 2):[5]

1. Participants register private keys. Patients and the hospitals obtain identity keys for signing changes to health records, and insurance companies obtain attribute keys to decrypt data

2. Patients authorize data access to the hospital, including their policy with the third-party payer
3. The hospital or practice encrypts the medical record according to the data access policy and submits it to the blockchain data pool
4. Blockchain consensus nodes verify the legitimacy of the source of medical data, then encrypted data is stored on the medical cloud and descriptions are written on the blockchain
5. The patient submits the claim to the insurance company, which obtains the address information of the medical information in cloud storage and searches the blockchain for the appropriate record. Because the insurance company's attributes comply with the patient's access policy, the encrypted file can be downloaded and decrypted using a private key to complete the claim.
6. Automatic claims processing using smart contract technology

Outcome

While the claims adjudication process has undergone significant innovation over the past several decades, improvement is still necessary to minimize inefficiencies and redundancies. Claims adjudication in its current form is complex, redundant, and largely manual, and blockchain technology has the potential to address these concerns.

COST TARGETS

Proponents claim that the various applications of blockchain technology within healthcare promise to bring significant cost reductions across the care delivery landscape. Initial examinations suggest that such a tool can be leveraged to tackle challenges in data interoperability, health information security, supply chain management, and administrative burdens. Undoubtedly, success in any of these challenges will impart benefits to patients, providers, payers, and an array of stakeholders along the way. However, evidence around exact cost changes attributable to blockchain disruptions in healthcare settings has been limited. Furthermore, the diversity of approaches to implementing any blockchain service- from the type of data stored to the tiered permissions, and consensus mechanisms to transaction speeds- suggests that it would be unwise to interpret one organization's success as a reproducible model in other environments. Therefore, we will take another approach to discussing the impact of blockchain on costs. After reviewing our current health IT systems, we will focus on a handful of financially burdensome challenges in healthcare, and use their cost footprints to illustrate the magnitude of the problems that blockchain can help to address.

Since the passage of the HITECH act in 2009, the federal government distributed tens of billions of dollars worth of subsidies to medical practices to implement certified electronic medical records (EMRs). Many healthcare facilities began integrating EMR systems into their patient care with the goal of improving treatment outcomes. However, implementation of EMRs is costly, and posed unique security and labor challenges for hospitals. EMR vendors such as

Epic, Cerner, and Meditech all offer varying prices that can depend on the size of practice, pre-existing health records, and specialty type. Major costs that go into utilization of EMRs involve licensing fees, hardware purchases and maintenance (e.g., servers), and labor costs for implementation and data migration. Other hidden costs can also encompass storage facility fees, staff training, and a potential initial loss of productivity. In a 2011 study, researchers found that EMRs cost $1,650 per full-time physician per month, [39] with an 8% and 4% reduction in overall productivity at 6 and 12 months following implementation. However, more recent study found that after a given time interval following EMR implementation, [40] hospitals demonstrated consistent improvements in mortality rates. While EMRs were pushed onto clinical practices around the country with the intention to improve patient care, they created a range of new challenges, and the literature demonstrated mixed results on the helpful effects of EMRs. [41–43] It serves as a fateful reminder that each of these technologies will carry unintended consequences as their disruption ripples through the landscape, and observers should be mindful of the time it takes for the technology to be integrated into standard practices when assessing impact and outcomes.

Prior authorizations

One of the most significant burdens on medical practices is prior authorization, a process through which insurance companies require physicians to submit paperwork justifying their desire to carry out any range of diagnostic and therapeutic procedures. While the intention on the part of payers was to reduce unnecessary medications and procedures, for many providers this turned into an obstructive process that interferes in their daily clinical decision-making (Figure 3)[44]. National surveys found that on average, physicians reported spending 43 minutes each day just interacting with their patients' health plans, converting to a cost of over $68,000 per physician per year. When you consider the entire clinical staff involved, the administrative burden specific to addressing prior authorization requests averaged to 20 hours each week per medical practice, including nearly 6 hours of clerical time and 13 hours of nurses' time. This incredible time cost converts to a range between $23 billion to $31 billion annually. [45] This time could instead be spent on seeing more patients, or having longer conversations with those patients who face multiple chronic conditions that demand close coordination and education.

Costs aside, a 2017 survey revealed how the practice of prior authorizations can interfere with clinical care. [46] A few examples include:

- Care delays: 92% of physicians reported having care delays as a direct result of filing prior authorizations, with 64% waiting at least one business day, and 30% reporting a wait of at least 3 business days to hear back from payers on their request.
- Treatment: 79% of physicians are sometimes, often, or always required to repeat prior authorization requests for prescription medications even when patients are stabilized on a particular treatment for chronic conditions, and 78% of physicians reported that the application process for prior authorizations have sometimes led to treatment abandonment.

- Administrative burden: 34% of physicians hire staff to exclusively file and manage prior authorization applications.

While eliminating such burdensome administrative demands on clinical practices would unlock substantial time and staffing resources towards increasing access and efficiency of patient care, such a change would be unlikely to pass. Legitimate concerns around cost accountability and defensive medicine suggest that payers will continue to require a permission process as a prerequisite to reimbursements. With that in mind, we can imagine how blockchain could be used to streamline steps across the prior authorization process.

Currently, prior authorizations can be requested for a range of services and therapies. In those patients who, according to the physician's clinical judgement, require a different insulin regimen for their diabetes or imaging studies for their abdominal pain, a smart contract could automate the approval. An insurer would need to clearly define their prerequisites for a given service: for example, the patient must trial certain drugs first as part of a step therapy, the hemoglobin A1C needs to be within a particular range, and perhaps the payer only includes certain products in their drug formulary. When the provider executes a request to initiate a new drug, they would trigger the smart contract to automatically examine the patient's health record to determine eligibility. Upon an automated review, if the patient is eligible, then the provider can receive near immediate authorizations to deliver care for that patient. Similarly, for abdominal pain, a smart contract could scan for certain diagnosis codes while also checking for contraindications to care, and, in most of the appropriate cases, rapidly respond with an approval for the clinicians to continue their workup. While there will always be outliers and difficult prior authorizations for patients such as those requiring expensive treatments or complex care coordination, smart contracts can reduce the turnaround time and administrative burden for all requests by automating a certain volume that reflect standard care. This would free up administrative time and resources to focus on the remaining requests, and in time, smart contracts could evolve to better manage a greater volume of prior authorizations.

Payment Reform

Certainly a subject of equal celebration and controversy, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, replaced the Sustainable Growth Rate and consolidated a number of quality scoring mechanisms into two ambitious programs. The Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) provided two paths for physician practices, ACOs, and other provider groups to transition to value-based healthcare. By holding providers accountable to greater degrees of risk, CMS intended to reward those who performed well with a bonus positive adjustment of their total annual Medicare Part B reimbursement, as well as penalize those who are below the average by withholding an equal percentage of their Part B reimbursement. Given that Medicare Part B enrolled 52 million Americans in 2016, and the Congressional Budget Office projected enrollment to reach 70 million by 2027, [47] small percentage changes in total Medicare reimbursements could risk the viability of eligible practices across the country. Amendments to the proposed MACRA rule resulted in less stringent reporting requirements, but as other

penalties begin to take effect and similar value-oriented payment plans spread, providers will have little choice but to participate and build a data reporting strategy.

Currently, CMS is studying how data collection and reporting practices are influencing clinical workflows, and the challenges that providers are facing in having to participate in MIPS. [48] It is projected that there will be an annual cost of up to $1,796 per physician in order to submit quality measures for MIPS through the claims submission mechanism under CMS, or up to $1,206 per physician annually when performed through EMRs. [49] Outside of quality metrics, MIPS scoring also requires reporting data on care improvement activities, interoperability, and resource utilization. However, before CMS began implementing MACRA, reporting practices across the United States were already demonstrating staggering time and resource costs.

A survey of nearly 400 medical practices in 2014 attempted to quantify the burden that quality reporting practices placed on primary care (general internists and family physicians) and specialty physician groups (cardiologists and orthopedists). The data showed that on average, physicians and staff were spending 2.6 hours and 12.5 hours, respectively, per physician per week in dealing with quality measures. Notably, over 80% of this time was spent on “entering information into the medical record ONLY for the purpose of reporting for quality measures,” converting to an average cost to the practice of over $40,000 per physician per year. [50] This cost, if multiplied over the number of practitioners in just those 4 fields, would amount to $15.4 billion annually.

Another review from 2017 found that the average sized community hospitals (of 161 beds) each spend over $700,000 annually on the administrative aspects of quality reporting. Surveys revealed that many of these reporting requirements, which can be duplicative, required manual data extraction, distracting clinicians from their primary responsibility towards patient care. For examples, hospitals previously reporting to both the Meaningful Use program and Hospital Inpatient Quality Reporting program remarked that both programs defined the same measure differently, requiring reporting through different channels to two offices within CMS. [51] Such burdens have only been magnified under recent value-based purchasing models.

While physicians and policy makers may debate over the precise costs and administrative burdens of reporting requirements, what is fairly certain is that healthcare is headed in the direction of increasing transparency, and such quality reporting practices will only expand as CMS and private payers expect greater accountability from physician practices. EHRs have developed certain mechanisms to assist in reporting measures, but the need for manual labor persists, and EHR vendors may not maintain the capacity to design automated reporting processes that comply with the changing expectations of public and private payers. Ripe for disruption, this poses another opportunity for blockchain technology.

While current practices may require medical staff to organize and repackage specific outcomes measures from their EHR for distribution to various payers, a blockchain could assign each payer or government authority a specific set of permissions, defined according to the metrics requested by the insurance plan or auditing body. Each plan, whether it is under Medicare or a Blue Cross PPO, would be able to query that provider’s EHR and automatically fetch the

relevant de-identified metrics. Furthermore, as this occurs on a public ledger, the smart contract would only allow the assigned parties permission to query that data at the predetermined time intervals, protecting the sensitive data from breeches or interference. As quality reporting requirements change, the permission tier can be updated in the smart contract, and each insurer or division of CMS would again receive completed packages of data appropriate to their needs. While this would not eliminate all of the concerns that practices have with their EHRs, it presents an exciting opportunity to address a growing burden and potentially capture cost savings while enabling clinicians to spend more time caring for their patients.

MEDICAL RESEARCH

Smart contracts as they relate to interoperability also apply to research. [52] Through smart contracts, a researcher can be granted specific permission allowing him/her to view *only* the parts of the patient chart relevant to a his/her study. Thus, instead of redacting or anonymizing patient data, a smart contract would instead share only the aspects of the patient chart the researcher is allowed to view and thus protect the transfer of extraneous information. These contracts could be automated to execute each time the selected information type is updated or inputted, allowing seamless and instant transfer of research data as it is placed into the chart. This would not only guarantee anonymity, but ensure the investigator is not viewing other parts of the chart tied to the outcomes of the study. These contracts could be automated to execute each time the selected information type is updated or inputted, allowing seamless and instant transfer of research data as it is placed into the chart. [52]

A major limitation of medical research currently is the inability of researchers to search through patient data pools across the country outside of the electronic chart system that is used at the researchers' academic institution or hospital. Researchers starting a study or clinical trial have a strong tendency to overestimate the number of available patients in the data pool that meet their criteria. [53] These researchers performing chart reviews and case studies are potentially unable to include valuable patient data capable of increasing the thoroughness and statistical significance of their research. A linked system that allows efficient data sharing enables researchers to perform and reproduce more studies. [53]

With these new opportunities there is a necessary caution regarding patient rights and the control of the release of the private data to researchers. There are already concerns about the exposure of private health data in hospitals due to the multitude of medical roles and ever shifting schedules of healthcare workers. [54] Incorporating a blockchain system to medical data creates questions and concerns about the deidentified patient data being so readily accessible. The average patient has little knowledge about the research process and how his or her data is being used. With a decentralized blockchain system, patients would have to be more engaged in the research process to give consent for their data to be used for potential clinical trials. [7] This leads to the question of whether patients could be reasonably expected to pay close attention to their "smart contracts" to ensure that they are knowledgeable and in control of their health data.

REFERRAL MANAGEMENT SYSTEMS

Within medicine, referrals from primary care providers are often not converted into visits with a specialist. Approximately 23% of families with children in the community health setting experience incomplete referrals.[55] Further, of specialists who receive referrals, 68% report that they do not receive information from the primary care provider prior to the specific referral visits.[56] This inefficiency results in delayed or unobtained care for the patient, as well as unrealized revenue for the provider.

Most referral processes today are labor-intensive, relying on the manual transfer of patient information between offices as a last-priority task. For specialists who care for patients without a full record of their past medical history, care can be inefficient or even harmful in the wrong circumstances. This is not the fault of the patient, who may lack knowledge about the details of his medical history and medications, or the providers who have more patients to treat and a narrow picture of the patient's overall health.

Distributed ledger technologies, through a smart contract, can automate this process. The immutable ledger of referral transaction records can have the ability to transfer patient information and alleviate many communication-based problems associated with referrals.[57] However, there are currently no major projects focusing specifically on referral management outside of large-scale EHR blockchain projects, and more research is needed.

HEALTHCARE SUPPLY CHAIN

Supply chain is comprised of a complex system of entities that facilitate movement of a product from supplier to customer through a series of incremental steps that can occur over a wide geographical area. In large supply chains, such as in health care, visualizing each transaction in process under the current system is not practical. The data for handlers, intermediaries, and quality assurance is often stored in multiple locations and visible only to those with the proper permissions. This lack of transparency between the origin of the product and the consumer can have consequences, magnified further in health care, as patients and regulatory agencies are unaware of intended or unintended malpractices.[58]

According to PricewaterhouseCoopers, counterfeit pharmaceuticals are a $200 billion annual business, making them the largest portion of fraudulent goods sold worldwide each year. The WHO and Interpol both estimate that one million people die each year after taking counterfeit drugs, and in 2008, adulterated heparin originating from China killed hundreds of children in the United States.[59] Despite US and global initiatives to combat the counterfeit pharmaceutical industry, the supply is rarely traced, as they originate all over the world and are exchanged at several steps in many different areas.

Several blockchain projects are currently attempting to address this through smart contracts by which the data of medical products during the logistics process and handling can be stored and accessed real-time by the supplier, receiver, intermediaries, and regulators (Figure 4). A report published by PricewaterhouseCoopers references the potential for blockchain to incorporate

scannable barcodes at every exchange that the customer or government agency can review through an audit trail. All parties would be able to access the drug information for quality assurance. Meanwhile, audit trails highlight instances of compromises in the supply chain and eases the process of recalls, if needed.[60]

Modum is a private cryptocurrency project that seeks to monitor temperature compliance and adequate storing conditions by combining IoT sensors with blockchain technology to ensure patient protection from inactivated or affected medications.[61] FarmaTrust is a separate private cryptocurrency project seeking to monitor and regulate each supplier and handler, such that patients can use a smartphone application to scan their medications as they are delivered to them to confirm quality assurance.[62]

Larger private entities, such as IBM, are beginning to incorporate blockchain in their supply chain infrastructure. They have partnered with shipping giant Maersk, and 94 separate firms have already signed up to use this platform for their supply chain needs.[63] DHL and Accenture teamed up earlier this year as well to integrate transparency and traceability in pharmaceutical supply chains, [64] and the government of India is working with Oracle to transfer all medical products at India's Apollo Hospitals to a blockchain-powered system. [65] The experiences across these stakeholders will serve as a model for future innovations that aim to ensure the safety of pharmaceuticals and the medical supply chain more broadly.

Bottom Line

Many projects addressing supply chain through the blockchain solution are their infancy, and more data is needed to assess the long-term feasibility and efficacy of such endeavors.

DISCUSSION

In considering the contents of this report, the authors believe it is important to emphasize that blockchain technology in and of itself is not a panacea for data sharing issues across healthcare. However, blockchain technology may have useful applications in promoting interoperability, reducing costs, enhancing claims adjudication and licensure workflow, as well promoting public health through supply chain management. With that being said, there is a paucity of data regarding testing blockchain applications in the clinical setting, and additional research will be required to definitively show the utility of this technology. The authors of this report recognize that blockchain remains an early stage technology, and that technical innovations in this space may rapidly overcome existing drawbacks the technology faces today. We further note that blockchain platforms may serve as an architecture upon which other tools may be built.

To date, neither the AMA nor the AMA-MSS has explicit policy on blockchain technology. AMA Policy National Health Information Technology D-478.995 states:

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 continued 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, with physician input, 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 (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.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

This policy broadly encompasses principles that enhance interoperability, data portability, and EHR usability. While blockchain platforms can function as interoperability tools by functioning as EHRs or HIEs, there are a variety of blockchain applications outside of this sector, including authorization, claims adjudication, referral management systems, and supply chain management to counteract drug counterfeiting. Moreover, while blockchain decentralization and trustless infrastructure can enhance collaboration between systems, the development of federal standards and protocols for blockchain technology will play an essential role in the design and application of blockchain technologies. The authors believe physician input is critical into the development of blockchain standards for healthcare, and thus suggest the following recommendations to the AMA-MSS General Assembly regarding blockchain technologies.

RECOMMENDATIONS

As directed by MSS Resolution 25 - “Healthcare Applications for Blockchain Technology” at I-17, your CHIT and CEQM recommend the following:

1. Reaffirmation of existing AMA policy National Health Information Technology D-478.995; and
2. Our AMA will work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare; and
3. Our AMA will continue to monitor the evolution of blockchain technologies in healthcare and engage in discussions with appropriate stakeholders regarding blockchain development; and
4. The remainder of this report be filed.

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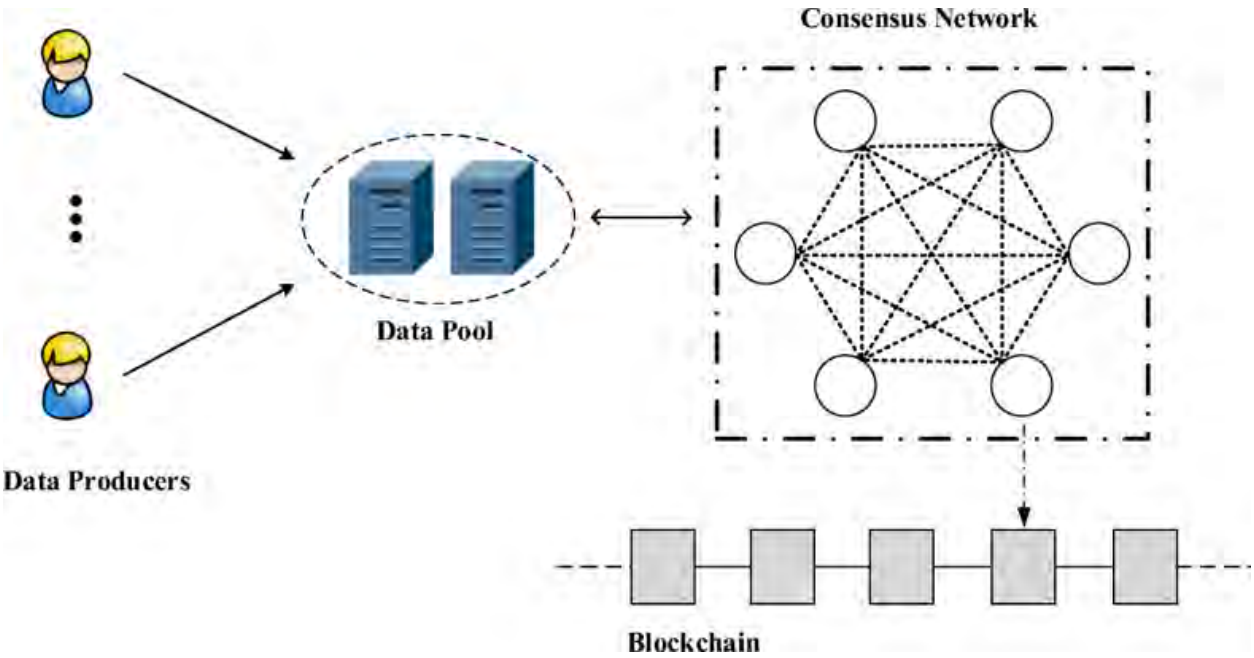

Figure 1. Simplified schematic of data flow prior to addition to a blockchain platform. Data is produced by particular stakeholders, enters the data pool, and independently validated by each node via a consensus mechanism. Validated data is timestamped and permanently added to the blockchain (e,g., “block”). Adapted from Wang et al. [5]

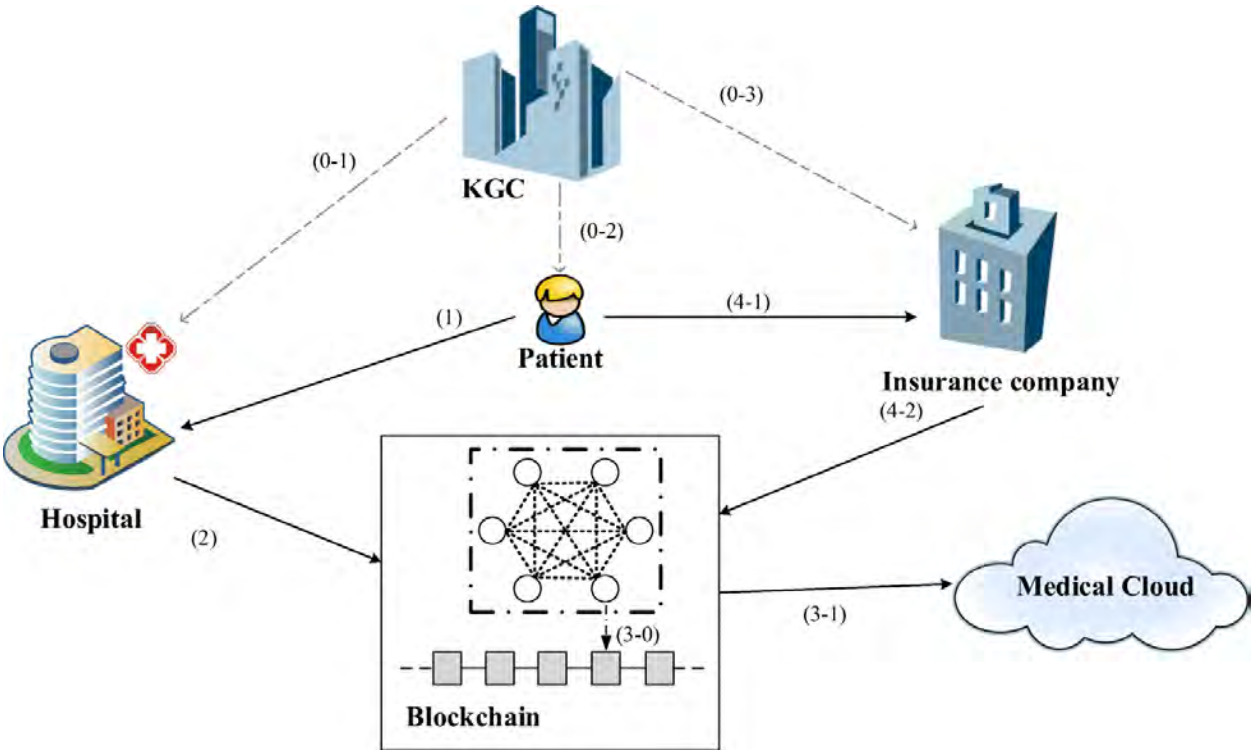

Figure 2. Proposed cloud-based and blockchain-based EHR to reduce claim denials and medical insurance fraud.[5]

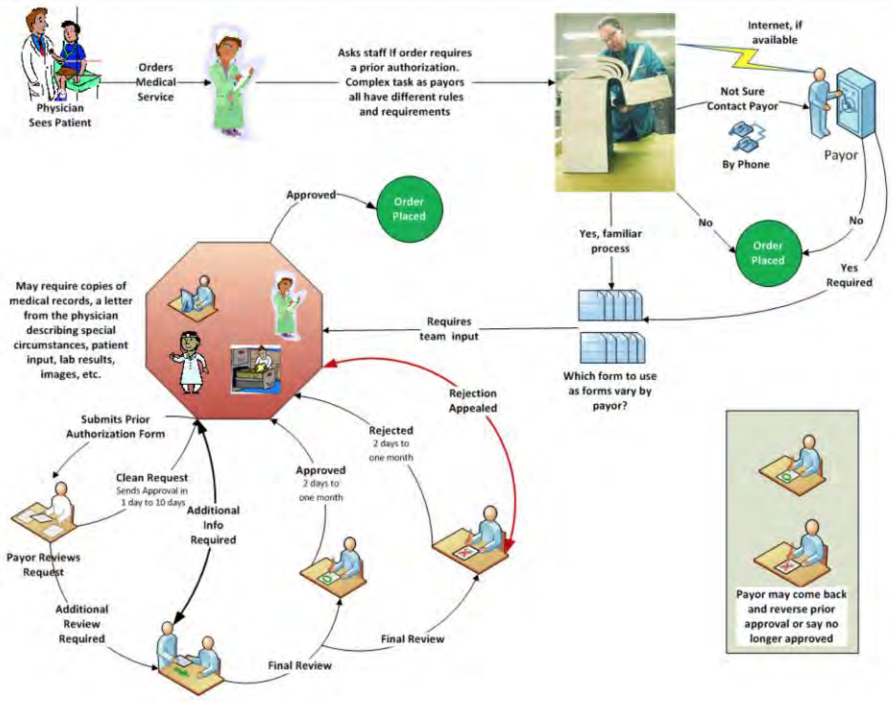

Figure 3. Prior authorization request workflow. [66]

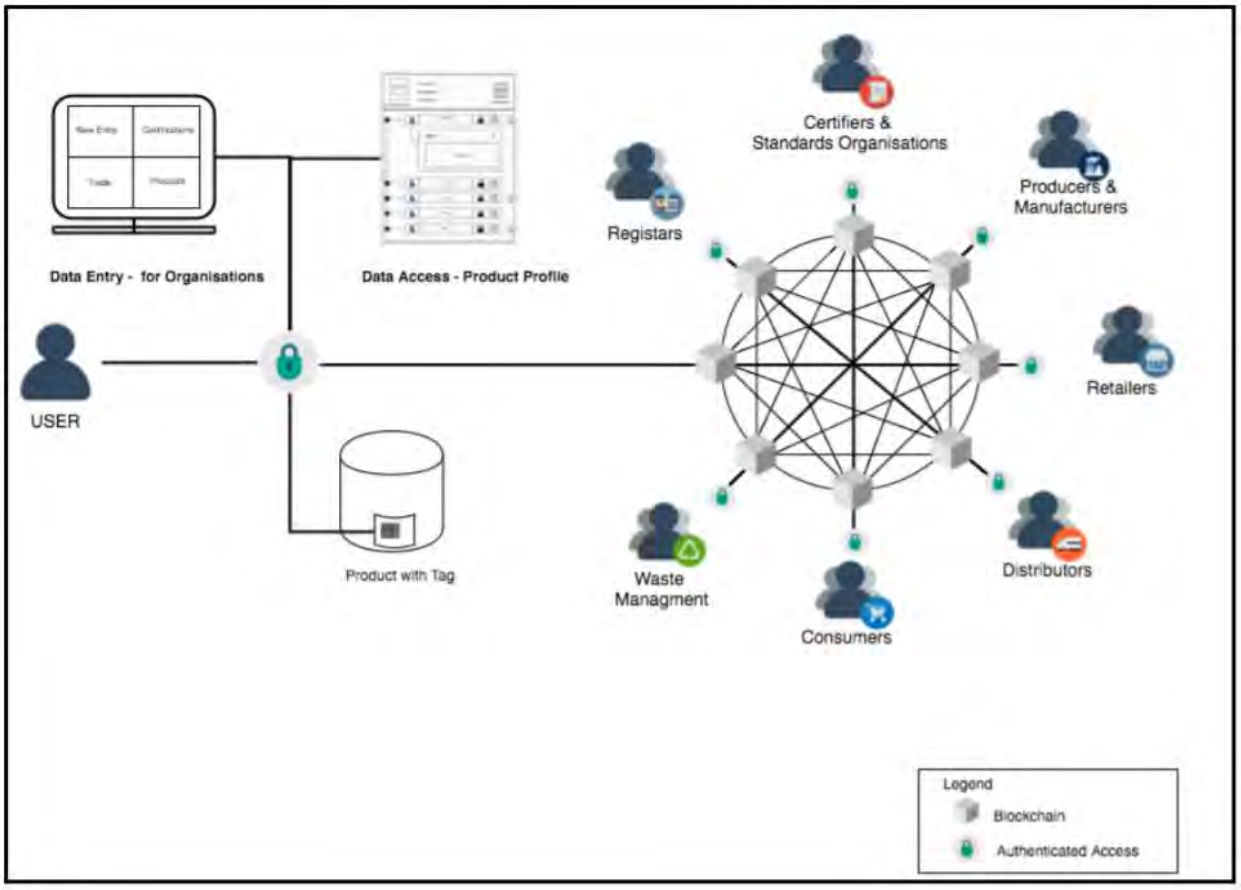

Figure 4. Overview of the proposed blockchain healthcare supply chain system.[58]

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE

MSS CEQM Report A, I-18

Subject: Increased Affordability and Access to Hearing Aids

Presented by: MSS Committee on Economics and Quality in Medicine

Referred to: MSS Reference Committee
(Lauren Engel, Chair)

EXECUTIVE SUMMARY

At the 2017 Interim Meeting, MSS Resolution 29, “Increased affordability and access to hearing aids and related care for the elderly,” was referred for further study.

This resolution asked the American Medical Association (AMA) to:

(1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly;
(2) support Medicare coverage of hearing aids and associated services for at least adults with moderate hearing loss (i.e., 40 - 70dB) before which cochlear implants are indicated (i.e.70 dB);
(3) advocate to state medical societies and professional societies to support policy for increased coverage of hearing aids and associated services for Medicaid beneficiaries;
(4) 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.

At the 2018 Annual Meeting, MSS Resolution 10, “Increasing Access to Hearing Aids”, was also referred to the Committee.

This resolution asked the AMA-MSS to

(1) stand in favor of a change in the delivery model for the treatment of mild-to-moderate hearing loss through supporting over-the-counter (OTC) hearing aids.

The Governing Council of the MSS assigned both of these resolutions to the Committee on Economics and Quality in Medicine for report back at the 2018 Interim Meeting. This combined report seeks to build off a preceding report presented by the AMA Council on Medical Service at the 2015 Interim Meeting, and will provide background on hearing loss, hearing aid coverage for adults, and their supply chain; summarizes relevant AMA policy and other pertinent reports; and makes policy recommendations.

Review of current literature demonstrates that age related hearing loss (ARHL) represents a major public health issue with significant and growing impact on society given the aging population.

Literature is reviewed explaining the relatively low utilization of hearing aids by eligible persons, revealing primary drivers including high costs and a lack of transparency around them; with other contributors including a heavily integrated manufacturer and dispenser supply chain and a market environment with little impetus to innovate. The Committee recognizes a need to modify systemic constraints. The Committee reviews and agrees with select recommendations from prior work done by the AMA Council on Medical Service for the 2015 Interim Meeting, the President's Council of Advisors on Science and Technology (PCAST), and the National Academies of Sciences, Engineering, and Medicine (NASEM): supporting policies that would increase access to hearing aids and related services, recognizing the potential of "unbundling" payment as a method of increasing access, supporting the move to an over-the-counter model for mild-to-moderate hearing loss, and maintaining the physician's integral role in hearing tests and Medicare reimbursement.

INTRODUCTION

During the 2017 Interim Meeting and the 2018 Annual Meeting, two resolutions pertaining to hearing aid affordability and insurance coverage were submitted to the Medical Student Section (MSS). The MSS voted to refer both resolutions for further study. Accordingly, your MSS Governing Council (GC) assigned these reports to your MSS Committee on Economics and Quality in Medicine (CEQM).

At the 2017 MSS Interim Meeting, MSS Resolution 29 "Increased Affordability and Access to Hearing Aids and Related Care for the Elderly" asked that:

> 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 (ie 40-70dB) before which cochlear implants are indicated (ie >70dB); 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.

At the 2018 MSS Annual Meeting, MSS Resolution 10 “Increasing Access to Hearing Aids” asked that:

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

Your Committee on Economics and Quality in Medicine (CEQM) researched and wrote a combined report making recommendations on the topic of hearing aid affordability, insurance coverage, and access.

BACKGROUND INFORMATION

Age related hearing loss (ARHL) is the most common sensory deficit, affecting more than two-thirds of adults over the age of 70, . Mounting evidence suggests that vision and hearing impairments increase the risk of costly health outcomes including disability, depression, cognitive impairment, and dementia.[1] By impeding the ability to care for oneself and manage other chronic health conditions, ARHL contributes to the loss of independence, a decrease in self reported health, and an increase in hospitalizations.[2] ARHL represents a major public health issue significantly impacting not only the health and well-being of patients, but also their families, caregivers, and society.

Medicare

The primary treatment for hearing loss is a properly-fitted hearing aid. Their use is associated with better hearing specific, as well as general health-related, quality of life.[3] Although it is estimated that 29 million US Adults could benefit from hearing aids, Section 1862(a)(7) of the Social Security Act explicitly excludes hearing aids and related exams from traditional Medicare coverage; a Section that has repeatedly been targeted by bills in Congress and noted to be a significant reason that less than 1 in 5 adults who could benefit use hearing aids.[1,4,5] This policy is such that a diagnostic hearing exam may be covered by Medicare Part B, but any hearing aid prescribed will not covered, and while the cost of hearing aids varies, the average patients spends $2360 for one hearing aid and, as in most cases of ARHL, double if they need two.[6]

Other Existing Coverage

Traditional Medicare (i.e. parts A and B) does not cover hearing aids, however it does cover audiologic exams ordered by physicians for patients presenting with a complaint of hearing loss. Audiological exams cannot be performed for routine screening of hearing loss and cannot be performed the same appointment as a hearing aid fitting.[7]

All Medicaid programs are required to cover hearing aids, exams, and related services for children under 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. However, only about half of the states have Medicaid programs that cover some aspects of hearing aids, exams, and related services, for adults.[8]

As of 2015, 28 states provide Medicaid coverage for hearing aids for those over the age of 21. The regulations vary by state with some requiring hearing tests, minimum hearing loss requirements, and monetary limits of coverage. Additionally, some providers do not accept Medicaid for hearing related service.[8]

Currently, only three states mandate that private health insurance plans cover, in some part, hearing aids and related services.[8,9] However, if an employer self-insures its employees' health care costs, the employer is exempt from state insurance regulations and mandates via federal ERISA regulation. Thus, there is no way to estimate what percent of private health insurance plans cover hearing aids and related services.

The Veterans Administration (VA) provides coverage for hearing aids and additional services to our veterans and is able to bulk-purchase hearing aids at an affordable cost, on average $400 per device, making it the country's largest purchaser of hearing aids.[10,11]

Hearing Aid Market/Supply Chain

The global hearing aid market is largely controlled by six manufacturers with vertically integrated distribution channels, comprising 98% of the world market and 80-90% of the US market in hearing aid technology. Their acquisitions of audiology and other dispensary practices has created an environment with little competition.[12,13] The remaining 26% of unaffiliated hearing aid dispensers some may still receive incentives from a manufacturer to recommend their brand.[14] A combination of vertical integration, incentives, and lack of evidence-based brand selection has led to dispensers recommending a single brand 75% of the time, a barrier for the patient looking to try different models.[15]

An additional barrier to patient access lies in the way hearing aids are bundled and sold to patients: more than 80% of hearing aid dispensers utilize bundling so that the purchase price of hearing aids includes additional services such as fitting, maintenance, counseling, rehabilitative therapy, and follow up care that often go unutilized.[15,16] This results in an increase in cost by 120% from the cost of the device itself causing patients who purchase to pay for services that they won't use and deterring other patients from buying potentially beneficial devices.[17]

Approaching Affordability

There have been proposals to improve the access of hearing aid technology through unbundling pricing strategies, development of personal sound amplification devices, and approval of the OTC sale of hearing aids.

Bundled pricing strategies for hearing aids lead patients to spend more money on services they may not utilize. In a comprehensive report on hearing health care in the US, the National Academies of Sciences, Engineering, and Medicine (NASEM) recommended, among other things, an increase in the transparency of hearing healthcare professional billing through unbundling quotes with clear itemization of charged services, giving consumers the ability to compare quotes from different dispensaries and choose what services to pay for.[8] An additional benefit may be that insurance coverage for hearing rehabilitative services, without coverage of hearing aids, could promote innovation and spur competition to develop more affordable hearing devices.[18]

In partial response to a market lacking in affordable and accessible options, some manufacturers have turned to the production of Personal Sound Amplification Products (PSAPs). These devices are not marketed at those with clinical hearing loss, and thus are not classified as medical devices, relieving them of FDA regulation, and by virtue of their direct-to-consumer sales, are often available at much lower prices. Furthermore, select PSAPs were associated with improvements in speech understanding with hearing loss that were comparable to results obtained with a hearing aid, leading one research team to suggest that in select cases, the devices may be appropriate for use in treating mild-to-moderate hearing loss.[5] The technological difference between PSAPs and hearing aids is thus a slim one, and in a few cases, it's been shown that the difference is purely an artificial one with some manufacturers marketing similar devices as a PSAP under one model name and as a hearing aid under another model name--and higher price.[17]

Although PSAPs provide a workaround to the high costs of traditional hearing aids, there remain drawbacks to using these devices including a lack of regulation.[19] The lack of regulation around PSAPs has led to little research being done on their safety (ie volume output) and efficacy. For example, few PSAPs in one study performed at the level of a traditional hearing aid for improvement of speech understanding.[5]

There has been recent interest in over-the-counter (OTC) hearing aids as a way to regain regulatory control over the direct-to-consumer hearing device market while still providing a low-cost and accessible solution.[8] Reports from both NASEM and PCAST point out the FDA's instrumental role in addressing this problem.[8,17] In light of some of these concerns, the FDA Reauthorization Act of 2017 established a new category of OTC hearing aids and tasked the FDA with proposing regulations for these devices by August 18, 2020. The new regulations, will allow the OTC sale of hearing aids for ARHL, and will shift power of choice to the consumer and promote competition within this new market sector.

After passage of FDA Reauthorization Act of 2017, the American Academy of Otolaryngology - Head and Neck Surgery declared support for OTC hearing aids for age related hearing changes after an examination has been done by a physician.[20] ;Consumers demonstrated their ability to self-fit OTC hearing aids in a thorough NIH funded double blind controlled trial and benefited from OTC hearing aids to treat age-related mild-to-moderate hearing loss. [21]

RELEVANT AMA POLICY AND FEDERAL LEGISLATION

Previous AMA policy and federal legislation interact with the asks of the referred resolutions.

Relevant to MSS I-17 Resolution 29

Resolution 29 calls for expanding Medicare and Medicaid coverage for hearing aids. Current federal statute does not permit this coverage Section 1862(a)(7) of the Social Security Amendments of 1965 states, "Notwithstanding any other provision of this title, no payment may be made under [Medicare] part A or [Medicare] part B for any expenses incurred for items or services . . . where such expenses are for . . . hearing aids or examinations therefor."[22] This federal law is reflected in federal regulation 42 C.F.R. 411.15(d), excluding Medicare coverage of hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids.[23] In 2015, a bill was introduced to the 114th Congress to strike "hearing aids or examinations therefor". Due to concerns about the high costs of these devices, the bill never left committee and was not re-introduced to the 115th Congress.[24]

Coverage of hearing aids under Medicare and Medicaid is also in conflict with current AMA policy and findings. Under AMA Policy H-165.856 "Health Insurance Market Regulation Section" Section 10(b), the AMA has taken the stance that "benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options". H-165.856 Section 10(b) directly contradicts MSS I-17 Resolution 29 resolved clauses 2 and 3.

Additionally, the AMA Council on Medical Service (CMS) studied the issue of hearing aid coverage in its report submitted at the 2015 Interim Meeting titled "Hearing Aid Coverage."[9] The Council concluded that covering hearing aids and services would be unduly expensive to the Medicare program. The Council noted that such services are covered through private insurance options such as Medicare Advantage (i.e. Medicare Part C) with more flexibility to the consumer. The option for Medicare Advantage coverage with riders is seen in the resultant AMA policy H-185.929 "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". In the same I-15 report and resultant AMA policy, the Council notably supported "the coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit". The report was adopted and resulted in a new AMA policy, H-185.929 "Hearing Aid Coverage", and the reaffirmation of Policies H-245.970 "Early Hearing Detection and Intervention" (initially adopted at HOD A-11) and H-165.846 "Adequacy of Health Insurance Coverage Options", specifically Section 2 (initially adopted at HOD A-11). Therefore, if MSS I-17 Resolution 29 were to be adopted,it would contradict the reasoning behind existing AMA policies.

Relevant to MSS A-18 Resolution 10

Resolution 10 from A-18 calls for the AMA to support over-the-counter hearing aids for age related hearing loss. Recently, The FDA Reauthorization Act of 2017 was signed into law and will be establishing a new category of over-the-counter hearing aids.[25] The FDA will propose regulations for these devices by August 18, 2020.

DISCUSSION

The Committee recognizes the importance of hearing health care and the need for a change in policy to improve access to hearing aids for those with ARHL. Currently, there remains a significant lack of adoption in hearing aids in part due to their cost. Thus, the Committee recommends MSS I-17 Resolution 29 Resolved clause 1 for adoption.

With regards to state Medicaid programs and traditional Medicare (i.e. parts A and B) covering hearing aids and associated services, the Committee recognizes that in addition to the cost prohibitive nature of wide scale coverage, the barriers to change surrounding AMA and federal policy are too high to justify a shift in AMA advocacy towards them. Thus, the Committee does not recommend MSS I-17 Resolution 29 resolved clauses 2 or 3 for adoption.

The previous Council on Medical Service (CMS) report from I-15, upon which this report seeks to build, recommends that traditional Medicare should cover hearing tests administered by physicians or a physician-led team. This was adopted as H-185.929 Section 4. The Committee agrees with Section 4 and recommends that H-185.929 Section 4 be reaffirmed.

The Council on Medical Service (CMS) I-15 report also notes that privately-run Medicare Advantage plans can provide coverage for hearing aid expenses for Medicare patients by offering riders on existing plans. Due to lack of transparency in benefit design and patient out-of-pocket costs of private Medicare Advantage plans, the Committee could not find econometric data to suggest which strategy is more cost-effective for patients: coverage of hearing aid expenses by Medicare Advantage plans via riders versus coverage of hearing aid expenses as part of usual benefits offered by Medicare Advantage plans.

In considering the current delivery model for hearing aids, the Committee supports policy that improves transparency in purchases involving hearing aids and related services. It supports the notion that improving transparency will allow consumers to understand what they are paying for and allow comparison, promoting best shopping practices. In regards to MSS I-17 Resolution 29 resolved clause 4, the Committee does not feel that unbundling of audiologic service costs for hearing aids should be specific to Centers for Medicare and Medicaid Services for two reasons: 1) traditional Medicare does not cover hearing aids and 2) unbundling should be applied to all hearing aid sellers and, if applicable, payors. Thus, the Committee recommends MSS I-17 Resolution 29 resolved clause 4 to be adopted with amendments.

The Committee recognizes that the hearing aid market has been dominated by a few major manufacturers, and recognizes the need for competition and innovation. The Committee also recognizes the introduction of OTC hearing aids through the FDA Reauthorization Act of 2017

and its foreseeable catalytic role. The Committee supports MSS A-18 Resolution 10 and believes it should be made external and revised for clarity. Thus, the Committee recommends MSS A-18 Resolution 10 be adopted as amended.

RECOMMENDATIONS

The Committee on Economics and Quality in Medicine recommends that the following be adopted in lieu of Res. 29 I-17 and Res. 10 A-18, and that the remainder of the report be filed.

1. 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.

2. That our AMA encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.

3. That our AMA support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss.

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REPORT OF THE AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
COMMITTEE ON GLOBAL AND PUBLIC HEALTH

MSS CGPH Report A, I-18

Subject:	Adverse Impacts of Delaying the Implementation of Public Health Regulations
Presented by:	MSS Committee on Global and Public Health; Arvind Haran, Member; Asmi Panigrahi, Vice Chair; Rowena Hann, Member; Allie Clement, Member; Rachel Ekaireb, Representative for Council on Science and Public Health
Referred to:	MSS Reference Committee (Lauren Engel, Chair)

INTRODUCTION

At its Interim 2017 meeting, the AMA-MSS referred for study MSS Resolution 21 titled “Adverse Impacts of Delaying the Implementation of Public Health Regulations”, which states the following:

> 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.

The MSS gave mixed testimony towards this resolution, supporting its spirit but citing vague definitions, high fiscal note of 12, and concerns of feasibility due to over-broad implications as reasons to refer Resolution 21 for study. The AMA-MSS Staff had similar concerns overly-broad scope, and provided a list of 72 delayed public health regulations obtained from searching the Office of the Federal Register on August 21st, 2017. As a result, your Governing Council (GC) assigned this report to the Committee of Global and Public Health (CGPH) with the following objectives:

1. Based on the 72 public health regulations put forth by staff, identify which are within

scope and feasibility of the AMA.

2. Of those public health concerns that are both within the scope of the AMA and feasible for it to speak to, based on existing AMA policy, identifying the most pressing concerns with delaying said public health regulations.

3. Offer solutions that allow the advancement of the noted public health regulation and identify if that solution is within the scope of the AMA and/or AMA-MSS and feasible for it to take action on, based on existing AMA policy.

In this report we begin by establishing basic definitions for terms mentioned in Resolution 21 and provide examples of delayed public health regulations that the AMA has historically acted upon. We will then elaborate on the methodology used to identify all delayed public health regulations that are within the scope of our AMA to act upon. Of these selected regulations, the most pressing, ongoing regulatory delays will be elucidated in our Discussion. This will be followed by our recommendations the AMA-MSS can act upon to preserve the author's intent behind Resolution 21.

BACKGROUND

Definitions:

The United States Department of Health and Human Services (HHS) states that regulations, also known as "rules," are created by agencies under the authority of Congress in order to help government carry out public policy.1 The regulations issued by HHS include topics such as health information technology standards, the Health Insurance Portability and Accountability Act (HIPAA), human subjects research and protections, and other health-related topics.1,2 Other agencies, such as the Environmental Protection Agency (EPA), Food and Drug Administration (FDA), and Centers for Medicare and Medicaid Services (CMS), also issue regulations that greatly impact human health. As part of the rulemaking process, there is a 30-day minimum effective date for rules, 60 day minimum for major rules, and no minimum for good cause.3 An agency may delay or withdraw a rule before it becomes effective which will delay the effective date.3

An adverse health effect can be defined as the causation, promotion, facilitation and/or exacerbation of a structural and/or functional abnormality with the potential of decreasing quality of life, contributing to disabling illness, or leading to premature death.4 In this report we define adverse medical consequences as the negative complications of governmental regulatory delays. It is well established in the medical community that reversible and irreversible abnormalities of minor magnitude can have genuine effects on health due to exacerbation of other disease processes or creating susceptibility to disease generally.4 Consequently, delays in federal regulation have the potential to cause adverse health effects, especially if these rules were originally created to decrease premature death, increase quality of life, or impact disabling illness. In this report, we hope to elucidate how delaying the effective date of such regulations may exacerbate adverse health effects, and how our AMA can take potential action in protecting the public health at large.

Political Context:

The act of delaying regulations for 60 days in order to review pending regulations is a common

practice when a new administration takes presidential office. In the first six months of the Trump Administration, 47 Obama-era regulations were suspended or placed under review, 14 of which came from the Environmental Protection Agency (EPA).5 On January 20, 2017, President Trump's chief of staff sent a memorandum directing the heads of all executive departments and agencies to freeze all pending regulatory actions and agency policy documents that had not yet gone into effect.6 This memorandum is similar to the regulatory freeze memorandum written by the Obama administration in 2009 except that the Trump administration memorandum also froze agency policy guidance documents that had not yet gone into effect. 4 On January 20, 2001, George W. Bush administration also issued a memorandum directing government agencies to temporarily delay the effective date of regulations 60 days to allow the new administration the opportunity to review the regulations.7

Previous AMA Action:

The AMA makes an effort to monitor the proposal, adoption and implementation of new rules and regulations, and responds according to its robust existing policy on public health. For example, in February, 2014 the FDA proposed a new rule that would modify the iconic "Nutrition Facts" label on all packaged foods. This proposal included increasing the font size of "calories", include new information about "added sugar", and require that "serving size" reflect real-world servings rather than an arbitrary amount chosen by the manufacturer.8 This proposed rule was consistent with existing AMA policy, which supports obesity prevention (D-440.954), limiting sugar-sweetened beverage consumption (H-150.933), reducing sodium intake (H-150.997), and transparent nutrition labels for foods that are based on current evidence (H-150.945, H-150.936, H-150.948). Pursuant to these AMA policies, and policy D-150.974, the AMA submitted supportive comments of this proposed rule during the public comment period. This rule was adopted by the Obama administration in May, 2016 and had been set to become effective July 26th, 2018. However, it was subsequently delayed by the Trump administration to go into effect January 1st, 2020. In response to this delay, the AMA sent a letter to the FDA commissioner Scott Gottlieb expressing opposition to this delay, citing its negative effects on public health, and the urgency of implementing these new and improved labels in the context of the obesity epidemic.9 Actions such as this provide precedent towards our AMA weighing in on delayed regulations that may potentially adversely impact public health.

METHODS

Baseline data on delayed public health regulations were collected by the AMA-MSS Staff by searching the Office of the Federal Register. Your CGPH then conducted a cross-sectional analysis of this sample of regulations to identify all relevant rules, with objective exclusion criteria designed in accordance with the assigned objectives set forth by your Governing Council. We also searched the AMA Correspondence Finder to confirm that there was no correspondence on the topics in question. All identified studies were then subjectively analyzed by committee members to report a final selection of the most pressing and actionable regulation delays. Results of the analysis were reported with accompanying background, public health impact, and relevant AMA policy of the identified rules. Specifics of each step of our unique data selection and analysis process are provided below.

- **AMA-MSS Staff Search**: The AMA-MSS Staff provided a list of 72 delayed public

health regulations obtained from searching the Office of the Federal Register on August 21st, 2017. Their search process used the terms "delay of applicability," "delay of compliance," "delay of effective date," "postponement of compliance" and variations of these phrases. Rules were not counted twice if a second related rule was published to extend the delay of a given regulation.

- **CGPH Cross Sectional Analysis** Three phases of data selection were employed for each of the respective three GC objectives provided to your Committee on Global Public Health.

- **GC Objective 1**: We developed the following set of four unique exclusion criteria to identify a cohort of regulations that fell within the scope of the AMA. These criteria were selected specifically to allow for a standardized and objective identification of relevant regulations within the original data set provided by the GC.

Table 1.1 Exclusion criteria to identify in-scope delayed federal regulations

Government Agency	If the AMA had no previous correspondence with the agency, the regulation associated with the agency was removed from the list. Information of past AMA correspondence with government agencies was obtained from the AMA Federal and State Correspondence Finder. The list of automatically excluded regulations based on agency was then manually revisited, and regulations that were within scope of the AMA or AMA-MSS without AMA-agency correspondence were manually selected to be included in the broad list
Recency	Regulation delays that occurred before 2017 were automatically excluded to focus on the most up-to-date delays and allow our analysis to accurately reflect the current regulatory environment.
Redundancy	Repeat incidences of a delayed regulation, or multiple delays of the same regulation listed within the original cohort of 72 identified regulations were excluded to optimize identification and analysis of key topics and themes. All attempts were made to include only the most up-to-date posted delay of the regulation within all analyses.
Relevant AMA Policy	Regulations were manually omitted from the distilled list after a cursory search in the AMA Policy Finder did not find areas of overlap between AMA policy and the subject matter concerning the delayed regulation.

- **GC Objective 2:** From the identified cohort of in-scope regulations, we chose to highlight the most pressing and pertinent regulations that our AMA and AMA-MSS could potentially take action on. This selection process was more subjective in nature and relied on the combined experience of your CGPH members. Standard practices and procedures of federal regulatory delays were also taken into account, including the institution of commonplace delays and freezes during the transition of administrations. Additional variables taken into consideration included:

Table 1.2 Subjective variables to identify most pressing delayed federal regulations

Ongoing delays	Ongoing delays were of importance to committee members because they were deemed to be the most actionable by the AMA.

Pending court cases	Delays which had affiliated pending court cases were noted by committee members because of the demonstrated interest and investment of stakeholders brought forth through litigation. The presence of a pending court case(s) also allows the AMA the option of submitting an amicus brief.
Completed delays	Completed delays that had considerable adverse public health outcomes during the delay period were of particular interest to the committee members because they demonstrated retrospective instances for our AMA to have become involved. Thus, these completed delays serve as ideal educational examples to be considered for future action.

- **GC Objective 3**: Using results of GC Objective 1 and 2, your Committee on Global Public Health performed an in- depth secondary subjective analysis of the identified regulations. Based on our cumulative research we provide our suggestions and actionable recommendations that would fall within AMA and AMA-MSS domain.

Using the exclusion process described above, we identified a cohort of 14 regulations that fell within scope of the AMA. The 14 regulations within this cohort were analyzed subjectively and the following three regulations were selected to be the most pressing in terms of their public health impact and feasibility for AMA action. The 11 remaining regulations were constituted of standard 60-day delays, reasonably justified delays to obtain public comments, and/or the public health risk was deemed low.

Table 2 Most pressing delayed federal public health regulations in 2017 selected by your CGPH

Title of Delayed Rule	**Agency**	**Document Citation**	**Status of Delay** (ongoing/pending court case/completed)
Chemical Disaster Rule - Clean Air Act	Environmental Protection Agency (EPA)	82 FR 27133	Completed August 17, 2018 (Court Case # 17-1181)
a) Standards of Performance for Municipal Solid Waste Landfills b) Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills	EPA	82 FR 24878	Ongoing (Court Case #18-cv-03237)
Certification of Pesticide Applicators	EPA	48 ELR 20046	Completed March 21, 2018 (Court Case # 17-cv-03434)

Below we describe the (1) background, (2) public health impact, and (3) relevant AMA and AMA-MSS policy of each of these three most pressing selected regulation delays.

1. Chemical Disaster Rule - Clean Air Act - EPA

Background: The “Chemical Disaster Rule” was created by the Environmental Protection Agency (EPA) under the Obama Administration in January 2017, but was delayed multiple times by the Trump Administration’s EPA until February 2019. The rule was created to enhance the safety and security of chemical facilities and reduce the risk associated with hazardous substances to workers, operators, and surrounding communities.10 It amends the decades old

"Risk Management Program" (40 CFR part 68) within the Clean Air Act, which failed to prevent thousands of fires, explosions, and chemical releases from chemical facilities that led to 59 deaths and over 17,000 injuries and hospitalizations.11,12 High profile chemical facility disasters include the explosions at the BP Oil Refinery in Texas City, TX in 2005 that killed 15 and injured 170 people;13 an explosion and fire at the Tesoro Refinery in Anacortes, WA in 2010 that killed 7 people;14 and a fire at the Chevron Refinery in Richmond, CA in 2012 that released a large plume of hazardous chemicals, leading to 15,000 residents in the city seeking medical treatment.15 These high profile incidents, and many others that led to adverse medical consequences for facility workers, first responders, and surrounding community, spurred the creation of the "Chemical Disaster Rule".10

The Rule aims to make chemical facilities safer for workers and surrounding communities by improving preventive measures, emergency response coordination, and accessibility of safety-related information to nearby communities upon request .10 Preventive measures include expanded safety audits, required root cause analysis of disasters and near-miss events, and investigative reports into recent incidents that must be incorporated into the facility's future chemical management planning. Improved emergency response coordination consists of annual meetings between chemical facility operators and local emergency responders and public health officials, along with periodic drills to ensure worker preparedness to a potential adverse event.10 These requirements apply to over 12,000 refineries, chemical manufacturers, and facilities in the US that use and store more than a Threshold Quantity of a regulated substance.10 This serves to protect 177 million Americans and 1 out of every 3 school children that attend schools within the vulnerability zone of a hazardous chemical facility.16 The EPA received 235 unique public comments from industry trade organizations, facilities, advocacy groups, state and local regulatory agencies, professional organizations, individual industry professionals, elected officials, and private citizens during the rulemaking process.17

The delay in the Chemical Disaster Rule effectively lasted from March 14, 2017 until August 17, 2018, a total of 1 year and 170 days. The delay was cut short because of the court case in the DC Circuit Federal Appeals Court, where it was ruled that the delay was "illegal and arbitrary".18

Public Health Impact of Delay: While the exact impact of the delay is difficult to measure, it is worth noting that over 69 known fires, leaks, and explosions occurred across the US during this delay under the current Risk Management Program.19 Many of these events led to hospitalizations, deaths, and facility and community evacuations which interfered with school and work. Toxic chemicals were released in large quantities during these events, some of which include ammonia, benzene, butadiene, methane, Hydrogen Sulfide, Sulfur Dioxide, xylene, toluene, hydrochloric acid, carbon monoxide.19 Of these chemical disaster events, the Arkema Plant explosion near Houston, Texas during Hurricane Harvey in August 2017 is worth exploring because it illustrates how the Chemical Disaster Rule could have mitigated the damage that occurred.

By the second day after Hurricane Harvey made landfall, flood waters reached six feet at the Arkema Plant in Crosby, Texas, eventually causing a power outage in the facility and loss of the refrigeration needed to cool the volatile organic peroxides on site.20 Dozens of workers moved the decomposing organic peroxides to freezer trailers. After assessing the facility's chemical

inventory, government officials determined explosions were imminent and established a 1.5 mile evacuation zone. This proved to be inadequate, as volatile organic compounds and dioxins were sampled several miles outside the evacuation zone.19 After one of the freezer trailers exploded, Arkema officials did not properly notify first responders of this event.21 Police officers and medical personnel became immediately ill upon entering the evacuation zone that was polluted by organic peroxide breakdown products. The first responders subsequently sued the Arkema plant for lacking preventative measures such as backup refrigeration, failing to provide accurate information about the harmful chemicals to first responders, and neglecting to adequately prepare for an anticipated major flooding event.22 A total of 62,000 pounds of toxic chemicals and 17,000 pounds of particulates were released in the flooding and fires.2324 At a press conference two days before this incident, Arkema officials claimed that there was no reason for concern because the plant chemicals were not toxic or harmful.25

This event demonstrated a need for improved preventative measures, emergency preparedness, and accessibility of information to the public,26 all of which the Chemical Disaster Rule would have achieved had it not been delayed. If the Chemical Disaster Rule had been in place at the proper time, the Arkema plant would have been required to update its Emergency action plan, practice emergency response drills, and meet with local police, medical personnel, and public health officials once per year, which could have occurred before the Hurricane.20 This alone may have been enough to mitigate some of the adverse health consequences felt by the first responders and the widespread pollution experienced by surrounding communities.

In general, minorities and low-income communities are disproportionately affected by chemical facility disaster events, such as spills, fires, and explosions. African Americans live within the danger zone of a hazardous chemical facility at a rate that is 75% higher than the nation as a whole, Latinos 60% greater, and the poverty rate in these high danger areas is 50% higher than the national average.27 It is important to mention that numerous chemical facilities are in hurricane-affected areas and are therefore at increased risk for chemical disaster events, thus making stronger preventative measures and emergency preparedness enforced by the Chemical Disaster Rule all the more important.28

Table 3.1 Relevant AMA-MSS and AMA Policy related to “Chemical Disaster Rule - Clean Air Act”

Code	**Policy**
135.002MSS	Environmental Protection
H-135.950	**Support the Health Based Provisions of the Clean Air Act**
H-135.991	Clean Air
H-135.942	Modern Chemicals Policies
H-135.92	Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures
H-180.944	Plan for Continued Progress Toward Health Equity

2. (a) Standards of Performance for Municipal Solid Waste Landfills and (b) Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills - EPA

Background: The Environmental Protection Agency (EPA) finalized two rules aimed at reducing emissions of municipal solid waste landfill gases on August 29, 2016 that were scheduled to go into effect on October 28, 2016.29,30 Municipal solid waste landfills (MSWLFs) are defined by the EPA as areas of land that receive household waste and non-hazardous wastes like commercial solid waste, sludge, and industrial solid waste31.

Both rules were directed towards limiting methane emissions, one of the most potent greenhouse gases, from new and existing landfills. Landfills constitute the third largest source of human-produced methane emissions in the United States and have undergone numerous changes in size, practices, and use of gas control methods and technologies since 1996, the year emission guidelines were first established. The new rules updated emission and control installation thresholds, gas treatment guidelines, monitoring, performance, and other operational standards. The EPA reasoned that a reduction of landfill gas would significantly reduce air pollution and protect public health and welfare from the impacts of greenhouse gas-induced climate change.29

The rules required states to submit implementation plans by May 30, 2017 for EPA evaluation. States that did not submit a state compliance plan would have a federal plan imposed on them by the EPA. However, on May 5, 2017, Scott Pruitt, the newly appointed director of the EPA, wrote a letter to various landfill industry leaders conveying the EPA's intent to reconsider several aspects of the rules in addition to issuing a 90-day stay of subparts of both rules.32 On May 31, 2017, the stay was published in the Federal Register.33 Although the 90-day stay expired in September 2017, the EPA has extended the deadline for states to submit implementation plans until March 13, 2020.34 On May 31, 2018, eight state attorneys general sued the EPA in California et al v Environmental Protection Agency, declaring that the EPA violated the Clean Air Act and requested that the EPA fulfil its statutory duty to implement and enforce the landfill emission guidelines.35 Further, the Environmental Defense Fund and the Natural Resources Defense Council sent a 60-day notice of intent to sue to the EPA on June 19, 2018.36 No suit has been filed yet as of September 25, 2018.

Public health impacts of delay: Air pollution from landfills, including methane, carbon dioxide, volatile organic compounds and other pollutants, contributes to climate change and poses significant public health concerns. This includes injury and death from prolonged heat waves, respiratory illnesses from ground-level ozone, and injury from increased flood, drought, wildfire, and storm strength and frequency.37,38 As a consequence, both air pollution and climate change put additional burdens on health care systems.39 Decades of research has also found that communities of color are much more likely to live near waste facilities,40,41 and disproportionately feel the effects of environmental hazards stemming from landfills.42

Several states, including California, New Mexico, Florida, and Delaware, have submitted or began developing implementation plans to the EPA. As of May 31, 2018, the EPA has "not approved any state plans or imposed a federal plan on any state that did not submit a state plan".35 Since air pollution and climate change are not contained by state borders, the health of individuals across the United States could continue to be detrimentally affected by landfill

emissions if the EPA does not enforce these regulations.43

Table 3.2 Relevant AMA and MSS Policy related to “Standards of Performance and Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills”

Code	Policy
135.002MSS	Environmental Protection
H-135.923	AMA Advocacy for Environmental Sustainability and Climate
H-135.950	Support the Health Based Provisions of the Clean Air Act
H-135.991	Clean Air
D-135.997	Research into the Environmental Contributors to Disease
H-135.996	Pollution Control and Environmental Health
H-135.973	Stewardship of the Environment

3. Certification of Pesticide Applicators - EPA

Background:

On December 12, 2016 EPA finalized stronger standards for people who apply restricted use pesticides (RUPs) through revision of the EPA’s Certification of Pesticide Applicators (CPA) Rule.44 Revisions to the rule included changes to strengthen competency standards as well as incorporate a minimum age requirement (18 years) for all persons using RUPs.45 The revisions were employed to adapt and strengthen 42-year old pesticide applicator certification standards in order to reduce the likelihood of harm, the levels of chronic exposure, and the incidents of ecological harm stemming from the misapplication of RUPs.

After the transition of federal administration, the effective rule date of January 4, 2017 was delayed numerous times, with the final delay of the effective date extending until May 22, 2018.46 The EPA cited reasons for the delays that included the prevention of confusion and disruption among regulatees and stakeholders if the rule were to go into effect sooner, as well as principles identified in the April 25, 2017 Executive Order “Promoting Agriculture and Rural Prosperity in America.” Of note, the EPA claimed that this action would not have disproportionately high and adverse human health or environmental effects on minority, low-income, or indigenous populations, as specified in Executive Order 12898 (59 FR 7629). February 16, 1994).46

The EPA received more than 130 comments relevant to the proposal to delay the regulation until May 22, 2018. While 18 comments were in support of the delay, such as those from state pesticide regulatory agencies, the vast majority of received comments were in opposition of the extension, including those from various non-governmental organizations representing a range of interests such as farm workers, environmental advocates, occupational or migrant health clinics and employment law, and many private citizens.

Notably, a coalition of farmworker unions and conservationists sued the Environmental

Protection Agency in June 2017 over the delays and the court ruled in their favor, saying that the Environmental Protection Agency "created substantial risk" for delay of critical protections for people exposed to dangerous pesticides.47 Advocacy groups Farmworker Justice and Earthjustice went on to file a joint lawsuit in April 2018 seeking Environmental Protection Agency meeting notes related to the CPA rule as well as another delayed regulation, the Agricultural Worker Protection Standard.48 The suit was filed in the U.S. District Court for the Northern District of California, which ultimately ruled that EPA was illegally delaying pesticide rules. The court declared the original March 6, 2017 date as the effective date, making the CPA ruling effective immediately.49

Public Health Impact of Delay:

The populations most likely to experience adverse health effects due to the delays of the Certification for Pesticide Applicators rule include approximately 2.5 million farmworkers, nearly 1 million pesticide applicators, as well as the families of those working on the frontlines of the agriculture industry.50 The health risk and effects of pesticide use are particularly significant given the well-established negative impacts of pesticide exposure, including impeding the neurodevelopment of children as well as causing multiple systemic complications in adults51. The scope of this delay is far-reaching, given that there are approximately half-a-million child farmworkers throughout the country, and as many as 20,000 workers are diagnosed with pesticide poisoning every year, according to the Centers for Disease Control and Prevention.52

In addition, at the time of revision the EPA itself had already highlighted the public health impact of the modified regulation. Rule drafters estimated that the proposed rule revision would have the potential to prevent up to almost 1,000 acute illnesses/year.44 By delaying the rule one year, these exposures would knowingly occur for an additional year. The health of immigrant, minority populations and vulnerable populations were possibly put at significantly higher risk as a result of these regulation delays, despite the EPA evidence-lacking claim that the rule would not adversely affect minority, low-income, or indigenous populations at the time of the delay.46 A 2014 study published in the American Journal of Industrial Medicine measured lifetime, residential, and occupational pesticide exposure in Latino farmworkers and non-farmworkers in North Carolina and found that pesticide exposure was related to social determinants of health. These included education, which was found to be inversely related to lifetime pesticide exposure for farmworkers and non-farmworkers, as well as immigration status, with farmworkers with H- 2A visas reporting greater residential pesticide exposure than those without H-2A visas.53

Table 3.3 Relevant AMA and MSS Policy related to "Pesticides; Certification of Pesticide Applicators"

Code	Policy
135.009MSS	Public Notification of Pesticide Applications
135.002MSS	Environmental Protection
H-135.922	Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures

H-365.986	US Efforts to Address Health Problems Related to Agricultural Activities
H-180.944"	**Plan for Continued Progress Toward Health Equity**

Delayed Regulations without Adverse Public Health Effects:

Of the original cohort of 14 identified delayed regulations, it is important to acknowledge that the 11 remaining regulations may not or did not pose serious public health risks. These delays may specifically serve to (1) grant additional time for industries to successfully comply with new or updated standards, or (2) provide a brief (60-day) regulatory freeze that typically takes place when federal administrations change leadership. The list of delayed regulations are listed below:

Table 4 Delayed public health regulations without adverse public health effects

Rule (Citation)	Agency	Description	Reasoning for delay	Length of delay
Center for Medicare & Medicaid Services (CMS) decision to delay Conditions of Participation for Home Health Agencies	Centers for Medicare & Medicaid Services	Revised the conditions of participation that Home Health Agencies (HHAs) must meet to participate in Medicare and Medicaid programs	Allow time for HHAs to prepare for and implement new rules	Published January 13, 2017 Delayed until January 13, 2018
Examinations of Working Places in Metal and Nonmetal Mines	Mine Safety & Health Administration (MSHA)	Amends existing standards for examination of working places in metal and nonmetal mines	Allow time for MSHA to provide training and compliance assistance	Published January 23, 2017 Delayed until October 2, 2017
Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)	Centers for Medicare & Medicaid Services	Implements three new Medicare Parts A and B EPMs and a Cardiac Rehabilitation (CR) incentive payment model, and implements changes to the existing CJR model under section 1115A of the Social Security Act.	Allow time for additional review, to ensure that the agency had adequate time to undertake notice and comment rulemaking to propose changes to the policy as warranted, and to ensure that participants have a clear understanding of the models and are not required to take needless compliance steps due to the rule taking effect for a short duration before any potential changes are effectuated	Published January 3, 2018 Delayed until January 1, 2018.
Juvenile Justice and Delinquency Prevention Act Formula Grant Program	Department of Justice	Authorized the Office of Juvenile Justice & Delinquency Prevention to provide annual grants to states to improve juvenile justice system and support prevention programs	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017

Confidentiality of Substance Use Disorder Patient Records	Department of Health & Human Services	Facilitated integration of care and new care delivery models while protecting privacy of patients being treated for substance use disorder	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017
Possession, Use, and Transfer of Select Agents and Toxins; Biennial Review and Enhanced Biosafety Requirements	Department of Health & Human Services	Finalized provisions to address toxin permissible limits of select agents, biosafety, and clarified regulatory language on list of biological agents that are a potential threat to public health	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017
National Vaccine Injury Compensation Program: Revisions to the Vaccine Injury Table	Department of Health & Human Services	Revised the Vaccine Injury Table	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017
Affirmative Action for Individuals With Disabilities in Federal Employment	Equal Employment Opportunity Commission	Clarified obligations that the Rehabilitation Act of 1973 imposes on federal agencies beyond not discriminating on the basis of disability	60-day regulatory freeze	Published January 3, 2017 Delayed until March 21, 2017
Control of Communicable Diseases	Department of Health & Human Services	Domestic and foreign regulations that strengthened HHS and CDC's ability to mitigate the introduction and spread of communicable diseases.	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017
Recognition of Tribal Organizations for Representation of VA Claimants	Department of Veterans Affairs (VA)	Allowed secretary of VA to recognize tribal organizations in similar manner as State organizations for providing assistance on VA claims	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017
340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties	Department of Health & Human Services	Set forth calculation of 340B ceiling price and application of civil monetary penalties	60-day regulatory freeze	Published January 19, 2017 Delayed until March 21, 2017

DISCUSSION

All three regulations identified by your CGPH as "most pressing" fell under the jurisdiction of the EPA. Our Results illustrate that Environmental regulations, especially those halted at the federal level, can pose a great burden to public health at large.

In the Annual 2018 House of Delegates meeting, the AMA voted affirmatively for the recommendations in Board of Trustees Report 33, which defined health equity "as optimal health for all," and prioritized it as "a goal toward which our AMA will work by... promoting equity in care;... influencing determinants of health; and voicing and modeling commitment to health equity." This vote marked a defining moment in shaping the scope of the AMA, as it broadly enables the AMA to take substantive action towards improving distal health factors that fall

under the umbrella of social determinants of health. One of the most fundamental social determinants of health is environment. The public health impact of environment and environmental policy has been well-studied by physicians, scientists, and sociologists and evidence suggests that minority and under-served populations are often the most susceptible to adverse environmental influences.54 Within the context of both the environment and environmental health, we go on to discuss the implications and opportunities for AMA action of each of these governmental regulation delays.

Chemical Disaster Rule: Although the Chemical Disaster Rule court case is resolved, the 20-month delay period presented a clear opportunity for the AMA to comment because numerous preventable chemical facility events across the country leading to evacuations, hospitalizations, deaths, and release of harmful chemicals into our environment occurred during this time. The Arkema plant explosion is a fitting example of a disaster event that could have motivated the AMA and other medical specialty societies, such as the American Association of Environmental Physicians and the American Association of Public Health Physicians, to weigh in on support for the timely implementation of the Chemical Disaster Rule. Such action would be supported by current AMA policy “Supporting the Health Based Provisions of the Clean Air Act” (H-135.950), which states that the AMA “opposes further legislation to weaken the existing provisions of the Clean Air Act.” The Board of Trustees report supporting medical equity provides yet another reason for AMA action, since chemical facility disasters disproportionately affect underserved and minority communities.

Municipal Solid Waste Landfills: The rules that addressed landfill gas emissions proposed to curb air pollution, a major contributor to climate change, and therefore reduce adverse health outcomes due to prolonged heat waves and increased frequency and intensity of extreme weather events. Proximity to landfills has further health consequences such as 38% higher exposure to nitrogen dioxide,55 which is associated with asthma,56 decreased lung function in children,57 low birth weight,58 and risk of cardiovascular mortality.59 Black, Latino, and lower-income communities are more likely to live within the “fenceline” of hazardous chemical facilities and solid waste landfills, putting communities of color at increased health risk from landfill pollution. As such, landfills constitute a social determinant of health as part of the built environment negatively affecting the health of vulnerable communities, which is in line with the AMA’s current priorities to address health inequities. Opportunities for the AMA to intervene in the EPA’s rule delay include (1) issuing a statement in opposition to the ongoing delays in implementation and (2) filing an amicus brief in the current lawsuit against the EPA, citing the deleterious health consequences of air pollution and landfill gas emissions.

Certification of Pesticide Applicators: The history, trajectory and potential impact of the CPA rule delay highlight the importance of enforcing regulations related to pesticide exposure. The delay especially demonstrates how vulnerable populations including children, minorities, and immigrants are especially at risk when it comes to the adverse effects of delaying such regulations. EPA records convey that the original revisions to the CPA rule were intended to strengthen pesticide regulation and specifically protect minors working as for-hire employees, many of whom are migrants who may speak limited English, as well as the surrounding communities.61

Of note, the health of immigrant and minority populations were possibly put at significantly

higher risk as a result of these regulation delays. Researchers of the previously referenced 2014 study on pesticide exposure and social determinants of health emphasized that associations between pesticide exposure and education level as well as immigration status in Latino populations were relevant for both occupational health policy-makers as well as health care providers. This conclusion offers an appropriate platform for AMA members to consider their own involvement in this situation.

Many other organizations issued statements, comments, and provided their stance on this specific rule and its delays. For instance, when the original pesticide regulation reforms were being considered in 2014, the American Academy of Pediatrics (AAP) publicly supported the revisions, citing both the proven biophysiologic toxicity of pesticides as well as the vulnerability of children's physical and emotional development.63,64Comments opposing the CPA delay were submitted to the EPA from over 30 non- governmental organizations representing a range of interests, such as farm workers, environmental advocates, of most relevant, occupational & migrant health clinics.

While the AMA supports efforts to "address health-related problems related to agricultural activities" (H- 365.986), the AMA does not have policy recognizing pesticide exposure as an environmental risk factor for disease. Therefore, though the AMA had multiple opportunities to express its disagreement or concern with the CPA delay, a lack of specific AMA policy on pesticides significantly hinders the action(s) it can take. Of note, the AMA has had policy related specifically to pesticide use and environmental health protection, but all of the relevant policies have been rescinded (See Chart C, Appendix). The most recently rescinded policy was H-55.990-Cancer Risk of Pesticides in Agricultural Workers, which encouraged the EPA and other governmental agencies to safeguard human and environmental health, emphasizing agriculture workers who may be exposed to pesticides. The policy was rescinded at A-16, with the CSAPH Representative citing "the release of long-awaiting improved rules in September 28, 2015".65 Given that the rules, though improved, did not go into effect until May 22, 2018, it was almost as if the policy was rescinded before the action/intent had been fully completed. It is possible that sunsetting of the other pesticide policies occurred due to similar or related reasons; regardless, this highlights why it is important for the AMA to institute resilient policy on pesticides risks that preserves principles previously passed in the House of Delegates.

Important Considerations: In addition to the above described regulation delays that adversely affected public health, our research and analysis revealed that new or recently proposed EPA regulations could pose threats to public health as well. In August 2018, for example, the EPA announced a proposal to allow states to set emission standards for coal-fueled power plants. The EPA's own analysis estimated over one thousand premature deaths annually due to increased particulate matter by 2030 in addition to thousands of cases of respiratory illnesses as a result of this proposal.66 This, among other examples, suggests that current leadership of the EPA is in the process of undermining its' mission of protecting the environment, and by extension, public health.67

It is worth noting that the AMA has had past correspondence with the EPA. In 2016, the AMA submitted an amicus brief to the DC Circuit Court of Appeals in support of the Clean Power Plan and its legality. The main argument presented in the brief was that the Clean Power Plan protects the public health at large and "Americans for generations to come" by regulating and

encouraging carbon emission reductions by 32% from 2005 to 2030.68 This example of the AMA weighing in on the legality of federal legislation from a public health perspective serves as precedent for taking action on pressing regulations that may be damaging to public health. The existence of substantial AMA policy supporting environmental regulations that protect public health (see Appendix) presents many opportunities for the AMA to directly respond to the EPA to urge enforcement of the agency's regulations.

CONCLUSION

Out of the 72 regulation delays analyzed in this report, 14 were determined to be within scope of the AMA, and three were selected as seriously harmful to public health. Of note, all three delayed regulations fell under the jurisdiction of the EPA. Common themes which emerged in our analysis of the three most pressing regulation delays include: (1) the rule delays were all met with opposition from relevant stakeholders (environmental NGOs, labor groups, organized medicine, etc.); (2) vulnerable populations, including children, minorities, and low-SES communities were disproportionately at risk of negative health consequences secondary to the delays; and (3) each delay presented multiple opportunities for the AMA to comment or take action.

The AMA has made a firm commitment to the promotion of health equity, and instrumental to this goal is the promotion of safe, healthy environments. Delays in environmental rules and regulations have the potential to have significant deleterious effects on public health and safety. However, some delays in regulation implementation are unavoidable, and may not be detrimental to public health. Therefore, it is critical that these be evaluated on an individual case-by-case basis, and for subsequent actions to be determined based on existing AMA policy. Monitoring and evaluating every rule/regulation delay that occurs may not be feasible for the AMA, which has numerous other legislative and advocacy priorities.69 However, future efforts by the AMA should focus on identifying regulations instituted by federal agencies actively involved with health-related policy, such as the aforementioned EPA rules, that may carry associated adverse health impacts if not implemented and enforced.

There are also avenues for future action that interested AMA-MSS members may pursue. Members are encouraged to collaborate with specialty organizations that can carry out more focused, actionable tasks in a shorter period of time, especially in the context of time-sensitive regulation delays. Potential avenues for collaboration may include resolutions, issues, or a specific action items with the American Academy of Environmental Physicians, American Association of Public Health Physicians or a number of other specialty medical societies. Students may also consider proposing AMA or AMA-MSS resolutions that are focused on a specific regulation(s) or topics elucidated within this report.

RECOMMENDATIONS

1. Resolved, that our AMA-MSS submit a resolution to amend 135.002MSS Environmental Protection to read as follows:

> Our AMA-MSS will ask the AMA to support strong federal enforcement <u>and timely implementation</u> of environmental protection regulations.

2. Resolved, That our AMA-MSS Governing Council ask the AMA to examine the feasibility of

filing an amicus brief highlighting the detrimental health effects of municipal solid waste landfill pollution in Court Case #18-cv-03237 (State of California et. al v EPA et. al)

3. Resolved, That our AMA-MSS submit a resolution to amend H-135.950 Support the Health Based Provisions of the Clean Air Act to read as follows:

> Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; (3) opposes further legislation, rules, and regulations that weakens the existing provisions of the Clean Air Act; and (4) support updates to the Risk Management Program, such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public

4. Resolved, That our AMA-MSS submit a resolution to:

> a) recognize the significant health risks associated with pesticide exposure and
>
> b) urge the EPA and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children.

5. Resolved, That our AMA-MSS Governing Council consider future requests of AMA-MSS Standing Committee(s) to analyze ongoing regulation delays that impact public health, as they deem appropriate.

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APPENDIX

Chart (A) Comprehensive AMA - MSS Policies Relevant to CGPH Report on MS 21

Environmental Protection - 135.002MSS: AMA-MSS will ask the AMA to support strong federal enforcement of environmental protection regulations. (AMA Res 80, A-82 Referred) (BOT Rep D, I-82 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I05) (Reaffirmed: MSS GC Rep F, I- 10) (Reaffirmed: MSS GC Rep D, I-15)

Public Notification of Pesticide Applications - 135.009MSS: 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)

Toward Environmental Responsibility - 135.012MSS: AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)

Chart (B) Comprehensive AMA Policies Relevant to CGPH Report on MS 21

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Support the Health Based Provisions of the Clean Air Act H-135.950 Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration,

through the Environmental Protection Agency, to withdraw the proposed New Source Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.

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.

Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures H-135.922 Our AMA supports: (1) the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA); and (2) educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients.

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.

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 policy-making 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.

Plan for Continued Progress Toward Health Equity H-180.944 Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Research into the Environmental Contributors to Disease D-135.997 Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Assurance and Accountability for EPA's State Level Agencies H-135.924 Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

US Efforts to Address Health Problems Related to Agricultural Activities H-365.986 Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities.

Pollution Control and Environmental Health H-135.996 Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

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.

Chart (C) Previous AMA Policies on Pesticides

Cancer Risk of Pesticides in Agricultural Workers H-55.990 Rescinded: CSAPH Rep. 01, A-16 The AMA: (1) urges the EPA and other responsible state and federal regulatory agencies to continue their efforts at safeguarding human and environmental health, and especially the health of agricultural workers who may be exposed to pesticides; (2) urges physicians to utilize the resources of local or regional poison control centers or the National Pesticide Information Center for the composition and toxicity of specific pesticides; and (3) through its scientific journals and publications, supports alerting physicians to the potential hazards of agricultural pesticides.

Effects of Pesticides H-135.974 Rescinded: CSAPH Rep. 3, A-06 The AMA urges Congress to continue to support and urge efforts by the EPA and other responsible state and federal regulatory agencies to determine the effects of pesticides on humans.

Pesticide-Herbicide Toxicity Instruction H-295.93 Rescinded: CME Rep. 2, A-13 The AMA encourages education in pesticide and herbicide toxicity to be provided at all levels of medical education.

Mirex - Carcinogen in Mice H-135.994 - Rescinded: CSAPH Rep. 1, A-10 Our AMA opposes use of pesticides with cumulative carcinogenic effects in government-funded projects for eradication of insect pests when instituted without consideration of ecological consequence.

Pesticide Safety H-135.988 I-86 Reaffirmed by CSA Rep. 4 - I-94 Rescinded The AMA supports expeditious congressional investigation to determine the safety of pesticide use.

Education Guide

Click each session title below to read more about these education opportunities.

All sessions are open to all meeting attendees. Italicized sessions were planned by members of the Medical Student Section.

Friday, November 9, 2018

Identifying victims of sex trafficking: The role of the physician

* Direct contracting with large employers: Is your organization an appealing partner?

*Can system-level and individual medical staff needs coexist? Spoiler: Yes!

* Coalition building: Fundamental steps for success

*Don't just survive, thrive: Wellness for young physicians

Providing care for child and adolescent refugees

2019 Medicare payment policy: Everything you need to know

Alternative privileging criteria: Evaluating competency without MOC

Health care think tank: Members moving medicine

The forgotten Americans: An introduction to US-Mexico border colonias

The FDA: What do they do for physicians and patients?

Opioid rehabilitation and care coordination: What physicians in training need to know

Mergers, acquisitions and partnerships in health care: Why is New York – Presbyterian in the Florida Keys?

Advocacy in action: Enacting change at a grassroots level

Sessions certified by the AMA for CME credit are indicated by an asterisk (*)

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Saturday, November 10, 2018

Scope of practice: How the AMA protects physicians' role in providing patient-centric care

Design thinking in health care

*Communications: Perfecting your elevator speech and your personal brand

Our turn to serve: How to improve health care for veterans

Caring for vulnerable populations: What can you can do to support LGBTQ+ youth

Train the trainer: Empowering your community to combat the opioid crisis

*Mind the gap: Improving undocumented patients' access to care

Is there a vaccine for burnout? Building resilience in the medical student community

Difficult conversations: End of life care

*Older and wiser: Assessing competency of elder physicians

How will the November elections affect LGBTQ patients and physicians?

*Acculturation: Continuous immersion and improvement for IMGs

The more things change: Issues facing senior women physicians

The business of improving workforce diversity

Sunday, November 11, 2018

Busharat Ahmad, MD leadership development program: How to earn an AMA leadership position

Sessions certified by the AMA for CME credit are indicated by an asterisk (*)

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AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Identifying victims of sex trafficking: The role of the physician

8:30 a.m.– 9:15 a.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

8:30 – 9:15 a.m. **Identifying victims of sex trafficking: The role of the physician**

Each year, 100,000-300,000 international and domestic minors in the United States are at risk of being trafficked for sex. Physicians can help reduce the risk of harm to victims by knowing what to look for and how to offer help. Become empowered with the knowledge needed to better identify, interview, and assist patients who are victims of sex trafficking.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Direct contracting with large employers: Is your organization an appealing partner?

8:45 a.m. – 10:45 a.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

8:45 a.m. – 10:45a.m. **Direct contracting with large employers: Is your organization an appealing partner?**
(2.0 AMA PRA Category 1 Credits™)

Recently, Henry Ford Health System (HFHS) and General Motors (GM) announced a direct contracting partnership in which HFHS provides a wide range of services to 24,000 GM employees. Join senior executives from both organizations to learn more about this venture and more broadly, how you can prepare your system to partner with large employers.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 2.0 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Can system-level and individual medical staff needs coexist? Spoiler: Yes!

9:30 a.m.– 10:30 a.m. | Friday, November 9 | Potomac D| Gaylord National Resort and Convention Center

ORGANIZED MEDICAL STAFF SECTION

9:30–10:30 a.m. **Can system-level and individual medical staff needs coexist? Spoiler: Yes!**
(1.0 AMA PRA Category 1 Credit™)

Multi-hospital systems are seeking standardization across their medical staffs to improve care and efficiency. While unification of all staffs under a single, system-wide medical staff organization is an option, this approach can overlook the unique needs of individual staffs and hospitals. Join the Organized Medical Staff Section to learn how systematization--or creating uniformity in select medical staff governance and operations areas without formal unification--can benefit your medical staff.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 *AMAPRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Coalition building: Fundamental steps for success

Noon – 1 p.m. | Friday, November 9 | Chesapeake D / E / F | Gaylord National Resort and Convention Center

Noon–1 p.m.

Coalition building: Fundamental steps for success
(1.0 AMA PRA Category 1 Credit™)

Physician-led health care coalitions can play an important role in promoting health on a local, state or national level. With a strong coalition, you can effect positive change through events, outreach, and engagement with the media, healthcare community, policymakers, and the public. If you are a physician leader interested in community advocacy and tapping into the power of a coalition, this program will help equip you with the knowledge and skills necessary to build and sustain a successful coalition.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Don't just survive, thrive: Wellness for young physicians

Noon – 1:30 p.m. | Friday, November 9 | Potomac C | Gaylord National Resort and Convention Center

ACADEMIC PHYSICIANS SECTION & YOUNG PHYSICIANS SECTION

Noon–1:30 p.m. **Don't just survive, thrive: Wellness for young physicians**
(1.5 AMA PRA Category 1 Credits™)

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Providing care for child and adolescent refugees

1 p.m. – 2 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

1 – 2 p.m. **Providing care for child and adolescent refugees**

The World Health Organization estimates that there are 258 million international migrants in the world today, many of whom lack adequate access to medical resources. With this statistic, it is likely that you will encounter individuals who fit this definition, including children and adolescent refugees. Explore what physicians are doing to care for this vulnerable population and learn what you can do to support these patients in your practice.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

2019 Medicare payment policy: Everything you need to know

1 p.m.– 2:20 p.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

1 - 2:20 p.m. **2019 Medicare Payment Policy: Everything You Need to Know**

Join Medicare payment policy experts to learn about the key changes in 2019 Medicare payment policies and the Quality Payment Program. A reaction panel with physician leaders from a variety of settings (urban, rural, private practice IPA, academic) will explore how the new rule could potentially impact integrated organizations.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Alternative privileging criteria: Evaluating competency without MOC

1:45 p.m.– 2:45 p.m. | Friday, November 9 | Potomac D | Gaylord National Resort and Convention Center

ORGANIZED MEDICAL STAFF SECTION

1:45–2:45 p.m.

Alternative privileging criteria: Evaluating competency without MOC

Medical staffs typically employ a combination of board certification, maintenance of certification (MOC), outcomes data, and other measures as proxies for physician competency. But with many physicians opting out of MOC, many physicians no longer practicing in hospitals, and other changes, medical staffs are increasingly looking to find alternative ways to evaluate applicants and members. Join the Organized Medical Staff Section to learn about and discuss holistic approaches to measuring competency for credentialing and privileging.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Health care think tank: Members moving medicine

2 p.m.– 3 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

2 – 3 p.m. **Health care think tank: Members moving medicine**

TED Talk-style ideas presented by medical students that highlight their passion for medicine. Each 10-minute presentation will be on a hot topic in medicine with recommendations for action. Come for the passionate students, stay for the innovative solutions to pressing problems in health care, and leave feeling inspired.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

The forgotten Americans: An introduction to US-Mexico border colonias

3 p.m.– 3:30 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

3 – 3:30 p.m. **The forgotten Americans: An introduction to US-Mexico border colonias**

Border colonias are rural border communities that exist along the US-Mexico border. These communities lack basic health resources, like clean water and access to medical care and as such, poverty and disease are rampant. Physicians can help the people living in these areas by providing health care services and through advocating for change. Learn about these communities and how you can make an impact and save lives.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

The FDA: What do they do for physicians and patients?

3:30 p.m. – 4:15 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

3:30 – 4:15 p.m. **The FDA: What do they do for physicians and patients?**

The Food and Drug Administration influences what drugs and medical devices are available to patients. While review processes seem lengthy, they are necessary to ensure that drugs and medical devices are safe for Physicians to prescribe to their patients. Learn about the FDA and its role in protecting Physicians and their patients.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Opioid rehabilitation and care coordination: What physicians in training need to know

4 p.m. – 4:45 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

4 – 4:45 p.m.

Opioid rehabilitation and care coordination: What physicians in training need to know

Physicians are critical to overcoming the opioid epidemic. Patients in recovery require focused care and their physicians apply a team-based care model to manage their care and recovery. Learn how physicians leverage this care model to provide care to this patient population.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Mergers, acquisitions and partnerships in health care: Why is New York-Presbyterian in the Florida Keys?

4:30 p.m. – 5 p.m. | Friday, November 9 | Magnolia 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

4:30 – 5 p.m.

Mergers, acquisitions and partnerships in health care: Why is New York-Presbyterian in the Florida Keys?

Hospitals and health systems are merging into multi-state networks. These networks include traditional and nontraditional players and the partnerships are transforming care delivery and the physician experience. Join the AMA-MSS to review this trend and discuss how it will shape care delivery and the physician experience.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Advocacy in action: Enacting change at a grassroots level

5 – 5:45 p.m. | Friday, November 9 | Chesapeake G & H | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

5 – 5:45 p.m. **Advocacy in action: Enacting change at a grassroots level**

Physician advocates play a vital role in influencing policymakers on matters that health policy and patient care. Despite serving in this important role, physicians rarely receive training on how to conduct advocacy activities and enact change at a grassroots level. Learn about what you need to influence change.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Scope of practice: How the AMA protects physicians' role in providing patient-centric care

7:30 a.m.– 8:30 a.m. | Saturday, November 10 | Potomac D | Gaylord National Resort and Convention Center

7:30 – 8:30 a.m.	**Scope of practice: How the AMA protects physicians' role in providing patient- centric care**

The AMA is partnering with state and specialty societies to protect the physician role in providing patient centered care. Learn how the AMA is partnering with state and specialty societies to protect the physician role in providing patient centered health care.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Design thinking in health care

8 a.m. – 9 a.m. | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

8 – 9 a.m. **Design thinking in health care**

As the leaders of the health care team, physicians are responsible for providing the best care possible and ensuring that errors are corrected before they harm any patient. Applying Design Thinking principles to solve issues ensures that creativity is used when developing solutions to the identified problems. Learn about this way of thinking and how you can apply these steps to improve care outcomes.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Communications: Perfecting your elevator speech and your personal brand

8:10 a.m. – 9:15 a.m. | Saturday, November 9 | Woodrow Wilson B | Gaylord National Resort and Convention Center

ACADEMIC PHYSICIANS SECTION

8:10 a.m. – 9:15a.m. **Communications: Perfecting your elevator speech and your personal brand**
(1.0 AMA PRA Category 1 Credit™)

Effective communication skills are a central clinical and professional function for physicians. As leaders in the both the clinical and academic arenas, physicians need to be able to identify their audience develop and deliver a clear, audience focused message. Join the AMA-APS to learn how you can maximize your communication efficacy.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Our turn to serve: How to improve health care for veterans

8:45 a.m.– 9:45 a.m. | Saturday, November 10 | Potomac D | Gaylord National Resort and Convention Center

8:45 –9:45 a.m.	**Our turn to serve: How to improve health care for veterans** There are more than 20 million veterans in the United States. This large patient population has its own unique set of physical and mental wellness challenges that are not addressed in medical training, but greatly influence the care outcomes for veterans. Join us to learn what you can do to improve care for this important population.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Caring for vulnerable populations: What you can do to support LGBTQ+ youth

9 a.m. – 9:30 a.m. | Saturday, November 10 | Azalea 3 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

9 – 9:30 a.m.

Caring for vulnerable populations: What you can do to support LGBTQ+ youth

According to the National Alliance on Mental Illness, LGBTQ+ individuals are almost three times more likely than their cisgender, heterosexual counterparts to experience a mental health condition. While acceptance of LGBTQ+ individuals has increased within the medical profession and society, many LGBTQ+ patients still encounter stigmatization, discrimination, and violence based on their sexual orientation and/or gender identity. Learn what you can do to improve the mental health of LGBTQ+ youth.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Train the trainer: Empowering your community to combat the opioid crisis

9:30 a.m. – 10 a.m. | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

9:30 – 10 a.m.

Train the trainer: Empowering your community to combat the opioid crisis

Timely administration of naloxone has saved thousands of lives. While physicians and other health and safety professionals receive training in overdose detection and naloxone administration, laypeople do not receive such training. As a physician or physician in training, you can reduce the number of lives claimed by opioid overdose by training local community members how to identify an opioid overdose and administer naloxone to reverse the effects. Learn how you can reverse the epidemic.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Mind the gap: Improving undocumented patients' access to care

10 a.m.– 11 a.m. | Saturday, November 10 | Potomac D| Gaylord National Resort and Convention Center

10–11 a.m.	**Mind the gap: Improving undocumented patients' access to care** *(1.0 AMA PRA Category 1 Credit™)* In our current political and social climate, a patient's access to care is influenced by their citizenship status. Physicians can improve care outcomes for patients, regardless of their citizenship status, by creating an inclusive care environment and decreasing barriers to accessing care. Join us to learn what you can do to improve care for members of this vulnerable population.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Is there a vaccine for burnout? Building resilience in the medical student community

10 a.m. – 11 a.m. | Saturday, November 10 | Exhibit Hall C | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

10 – 11 a.m.

Is there a vaccine for burnout? Building resilience in the medical student community

The pressures of medical school can have a major impact on students' mental health and wellness. Now more than ever, medical students need to be able to identify the appearance of burnout in themselves and their peers. In having this knowledge, students will be able to support one another and build resilient peer networks. Learn how you can solve the burnout epidemic and build resiliency among your peers.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Difficult conversations: End of life care

11 a.m. – Noon | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MEDICAL STUDENT SECTION

11 a.m. – Noon **Difficult conversations: End of life care**

End of life discussions are a difficult and necessary part of medicine. While important, physicians do not learn how to compassionately and comprehensively discuss death with patients and their families during their training. Learn how to effectively facilitate these important conversations with your patients and their families.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Older and wiser: Assessing competency of elder physicians

Noon – 1:30 p.m. | Saturday, November 10 | Woodrow Wilson A | Gaylord National Resort and Convention Center

ACADEMIC PHYSICIANS SECTION, COUNCIL ON MEDICAL EDUCATION & SENIOR PHYSICIANS SECTION

Noon – 1:30 p.m.

Older and wiser: Assessing competency of elder physicians
(1.5 AMA PRA Category 1 Credits™)

Current research suggests that physician competency and practice performance decline with increased years in practice (Hawkins, 2016). Knowing when to give up practice is an important decision for most physicians, but many physicians lack information and education regarding the effects of aging on practice. This program will review current evidence and research regarding the assessment of senior/late career physicians to help attendees understand the uncertain and variable influences of aging on clinical and cognitive competency.

The AMA's Council on Medical Education worked in collaboration with the Senior Physicians Section to identify organizations to work together on the AMA Work Group on Assessment of Senior/Late Career Physicians over the last three years. Council on Medical Education Report 1-I-18 will be the product, in part, of these discussions.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

How will the November elections affect LGBTQ patients and physicians?

5:00 p.m.– 7:00 p.m. | Saturday, November 10 | Potomac 2 | Gaylord National Resort and Convention Center

ADVISORY COMMITTEE ON LGBTQ ISSUES

5:00–7:00 p.m. **How will the November elections affect LGBTQ patients and physicians?**

How will the November elections affect LGBTQ patients and physicians? The Advisory Committee on LGBTQ Issues will host a townhall to explore how the November elections could impact LGBTQ health policy.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Acculturation:

Continuous immersion and improvement for IMGs

5:15 p.m.– 5:45 p.m. | Saturday, November 10 | Potomac 3 & 4 | Gaylord National Resort and Convention Center

INTERNATIONAL MEDICAL GRADUATE SECTION

5:15–5:45 p.m.

Acculturation: Continuous Immersion and Improvement for IMGs
(0.5 AMA PRA Category 1 Credit™)

International Medical Graduates (IMGs) face challenges navigating American culture and societal norms when practicing medicine in the United States. These differences influence how IMGs engage with their patients, their colleagues and other members of the care team. Acculturation can help with navigating these differences and empower you with the tools and knowledge needed to navigate American culture and avoid common misunderstandings. Join the AMA- IMG Section to learn about acculturation and resources that are available to help you improve your interactions with others.

The AMA is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AMA designates this live activity for a maximum of 0.5 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

The more things change: Issues facing senior women physicians

6:00 p.m.– 6:30 p.m. | Saturday, November 10 | Woodrow Wilson D | Gaylord National Resort and Convention Center

WOMEN PHYSICIANS SECTION

6:00–6:30 p.m. **The more things change: Issues facing senior women physicians**

Come hear cutting edge research by our 2017 Joan F. Giambalvo Fund for the Advancement of Women grant winners.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

The business of improving workforce diversity

6 p.m.– 7 p.m. | Saturday, November 10 | Potomac 6 | Gaylord National Resort and Convention Center

MINORITY AFFAIRS SECTION

6 – 7 p.m. **The business of improving workforce diversity**

Immediately following the HOD Opening Session at 6pm on Saturday, November 10, MAS will hold its business meeting, which will feature a panel discussion on physician entrepreneurs and their efforts to improve the pipeline of, and career development for underrepresented minorities in medicine. All are welcome.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Busharat Ahmad, MD leadership development program: How to earn an AMA leadership position

2:30 p.m.– 4:00 p.m. | Sunday, November 11 | Potomac 4 & 5 | Gaylord National Resort and Convention Center

INTERNATIONAL MEDICAL GRADUATES SECTION

2:30–4:00 p.m. **Busharat Ahmad, MD leadership development program: How to earn an AMA leadership position**

Join the AMA-IMG Section to learn how to become a leader within the AMA.

Election Manual

The MSS Assembly will elect the following positions at the 2018 MSS Interim Meeting:

- Governing Council Chair-elect
- Medical student member of the AMA Board of Trustees

Additionally, the MSS regions will elect Regional Delegates and Alternate Delegates for 2019.

Visit the MSS meeting documents webpage to download the Election Manual:
https://www.ama-assn.org/about/mss-meeting-documents

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Convention Committees

Thank you to the following MSS members for their contributions to this meeting!

Credentials Committee	
Amanda Whitehouse, Chair	Steven Mowen
Laura Barrera	Lindsay Murphy
Gabriel Conley	Nadia Sion
Glen McClain	Olivia Sonderman
Emily Miller	Rachel Whittaker
HOD Coordination Committee	
Hari Iyer, Chair	Irraj Iftikhar
Adam Roussas, Chair	Dayna Isaacs
Nathan Carpenter, Vice Chair	Anil Mishra
Adam Panzer, Vice Chair	Thomas Pak
Kristan Baird	Enrique Rodriguez-Fhon
Kyle Bevers	Rahul Shah
Hetal Bhatt	Abby Solom
Hospitality Committee	
Jimmy Brown, Chair	Pareena Kaur
Anisa Bravo	Madyson Riddell
Logistics Committee	
Nicholas Yeisley, Chair	Priya Jain
Kristan Baird	Sarah Joseph
Farhad Ghamsari	

Parliamentary Procedure Committee	
Michael Nitz, Chair	Jordan Lippincott
Bukky Ajagbe	Justin Magrath
Harshitha Dudipala	Manasa Melachuri
Reference Committee	
Lauren Engel, Chair	Moudi Hubeishy
Lauren Benning, Vice Chair	Krishna Kinariwala
Ankita Brahmaroutu	Stephanie Strohbeen
Haidn Foster	
Rules Committee	
Subhan Toor, Chair	Rohan Khazanchi
Jeffrey Breton	Pooja Nair

Governing Council Action Items

The AMA Medical Student Section Governing Council wants to ensure that every MSS member's voice is heard. If you have a concern or new idea that you would like to see addressed or brought to the attention of the AMA, please complete the form available at https://www.ama-assn.org/eform/submit/governing-council-action-item.

The following action items have been submitted since the 2018 Annual Meeting:

(1) Protecting affordability of publicly funded drugs discovered at universities in developing countries

Submitted by anonymous on August 20, 2018

Short Summary of the Problem/Issue
Current licensing guidelines at research universities are unclear and do not effectively protect affordability of drugs in developing countries. When licensing their innovations, universities are hesitant to negotiate with pharma around affordability in the developing countries mainly due to fear of competition from other institutions. However, pharma increasingly relies on universities and federal agencies for drug invention. Thus, all universities across the nation must leverage their power and social responsibility in these negotiations. In 2007, leadership at 12 institutions from across the U.S. along with the AAMC crafted the Nine Points to Consider in Licensing University Technology. While the 9th point in that guideline represented the first step in addressing the issue of affordability of drugs in developing countries, it lacks concrete steps, even for those institutions that have chosen to endorse it.

Action Requested
- Issue an endorsement of the 9th point in the Nine Points to Consider in Licensing University Technology regarding consideration for affordability of drugs in developing countries.
- Call on the appropriate stakeholder organizations such as Association of American Universities (AAU) and Association of American Medical Colleges (AAMC) to create sample contract language that could be incorporated into licensing contracts of this nature to legally embody the 9th point, such as required humanitarian use clause(s)
- Publicize instances of failure to protect fair access to essential medicine in electronic communications such as AMA Morning Rounds.
- We request that the issue of continued lack of fair access to essential medicine be raised for discussion at a future AMA meeting.

Supporting Policies
Existing AMA policies (250.018MSS, 100.014MSS, H-100.963, H-460.981) outline the importance of fair access to essential medicine in the developing world, however affordability is still not being considered in the standard practice of licensing new essential medicine. We believe that Our AMA can play a crucial role in improving the present situation.

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(2) Opposing Firearm Manufacturing Using Technology Accessible from the Home

Submitted by Dayna Isaacs on September 1, 2018

Short Summary of the Problem/Issue
On August 1, 2018, the U.S. State Department prepared to allow the “Defense Distributed” firm to publish gun blueprints for 3-D printers, although this was overturned by a federal judge. However, hundreds of blueprint designs were reportedly downloaded prior to this court decision. With access to a 3-D printer, downloading a firearm blueprint enables the manufacturing of a plastic, untraceable firearm without a criminal background check or a serial number requirement. Possible firearms include an AR-15 semi-automatic assault weapon. Using blueprints to 3-D print firearms will increase access to guns in an unregulated manner, resulting in a likely increase in the number of homicides and suicides.

Action Requested
- Issue a statement of concern to Congress, the Bureau of Alcohol, Tobacco, Firearms and Explosives, and other relevant entities.

Supporting Policies
- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
- Firearm Availability H-145.996
- Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
- Control of Non-Detectable Firearms H-145.994