AMA
AMERICAN MEDICAL ASSOCIATION

MEMBERSHIP MOVES MEDICINE™

HOUSE OF DELEGATES

HANDBOOK

2019 Annual Meeting
Hyatt Regency Chicago | June 8–12

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Visit ama-assn.org/hod-2019-business to access the handbook online.

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **REMINDER*: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (A-19)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Sunday, June 9, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   Listing of Delegates and Alternate Delegates
   Officials of the Association and AMA Councils
   House of Delegates Reference Committee Members

8. **Note on Order of Business**

9. **Summary of Fiscal Notes**

FOLLOWING COLLATED BY REFERRAL

10. **Report(s) of the Board of Trustees - Jack Resneck, Jr., MD, Chair**
    01 Annual Report (F)
    02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
    03 2018 Grants and Donations (Info. Report)
    04 AMA 2020 Dues (F)
    05 Update on Corporate Relationships (Info. Report)
    06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
    07 AMA Performance, Activities and Status in 2018 (Info. Report)
    08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019 (Info. Report)
    09 Council on Legislation Sunset Review of 2009 House Policies (B)
    10 Conduct at AMA Meetings and Events (F)
    11 Policy and Economic Support for Early Child Care (D)
    12 Data Used to Apportion Delegates (F)
    13 Employed Physician Bill of Rights and Basic Practice Professional Standards (G)

14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (B)

15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization (G)

16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients (D)

17 Ban on Medicare Advantage "No Cause" Network Terminations (B)

18 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)

19 FDA Conflict of Interest (B)

20 Safe and Efficient E-Prescribing (B)

21 Augmented Intelligence in Health Care (B)

22 Inappropriate Use of CDC Guidelines for Prescribing Opioids (B)

23 Prior Authorization Requirements for Post-Operative Opioids (B)

24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion (F)

25 All Payer Graduate Medical Education Funding (C)

26 Research Handling of De-Identified Patient Information (Amendments to C&B)

27 Advancing Gender Equity in Medicine (F)

28 Opposition to Measures that Criminalize Homelessness (D)

29 Improving Safety and Health Code Compliance in School Facilities (D)

30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs (B)

31 Non-Payment and Audit Takebacks by CMS (G)

32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff (G)

11. Report(s) of the Council on Constitution and Bylaws - Jerome C. Cohen, MD, Chair

01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing (Amendments to C&B)

02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws (Info. Report)

12. Report(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair

01 Competence, Self-Assessment and Self-Awareness (Amendments to C&B)

02 Physician Assisted Suicide (Amendments to C&B)

03 CEJA's Sunset Review of 2009 House Policies (Amendments to C&B)

04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report (Info. Report)

05 Discrimination Against Physicians by Patients (Info. Report)

13. Opinion(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair

01 Amendment to E-2.2.1, "Pediatric Decision Making" (Info. Report)

14. Report(s) of the Council on Long Range Planning and Development - Alfred Herzog, MD, Chair

01 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

15. Report(s) of the Council on Medical Education - Carol D. Berkowitz, MD, Chair

01 Council on Medical Education Sunset Review of 2009 House Policies (C)

02 Update on Maintenance of Certification and Osteopathic Continuous Certification (C)

03 Standardizing the Residency Match System and Timeline (C)

04 Augmented Intelligence in Medical Education (C)

05 Accelerating Change in Medical Education Consortium Outcomes (Info. Report)

06 Study of Medical Student, Resident, and Physician Suicide (C)

07 For-Profit Medical Schools or Colleges (Info. Report)

16. Report(s) of the Council on Medical Service - James G. Hinsdale, MD, Chair

01 Council on Medical Service Sunset Review of 2009 AMA House Policies (G)
02 Covering the Uninsured Under the AMA Proposal for Reform (A)
03 Medicare Coverage for Dental Services (A)
04 Reclassification of Complex Rehabilitation Technology (A)
05 The Impact of Pharmacy Benefit Managers on Patients and Physicians (A)
06 Preventive Prostate Cancer Screening (A)
07 Hospital Consolidation (G)
08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor (G)
09 Health Plan Payment of Patient Cost-Sharing (G)
10 Alternative Payment Models and Vulnerable Populations (G)
11 Corporate Investors (G)

17. Report(s) of the Council on Science and Public Health - Robyn F. Chatman, MD, Chair

01 CSAPH Sunset Review of 2009 House of Delegates Policies (E)
02 Drug Shortages: 2019 Update (Info. Report)
03 Low Nicotine Product Standard (D)
04 Vector-Borne Diseases (D)

18. Report(s) of the HOD Committee on Compensation of the Officers - Marta J. Van Beek, MD, Chair

01# Report of the House of Delegates Committee on Compensation of the Officers (F)

19. Joint Report(s)

01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure (C)

20. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker

01 Recommendations for Policy Reconciliation (Info. Report)

21. Resolutions

001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations (Amendments to C&B)
002 Addressing Existential Suffering in End-of-Life Care (Amendments to C&B)
003 Conforming Sex and Gender Designation on Government IDs and Other Documents (Amendments to C&B)
004 Reimbursement for Care of Practice Partner Relatives (Amendments to C&B)
005 Right for Gamete Preservation Therapies (Amendments to C&B)
006 Use of Person-Centered Language (Amendments to C&B)
007 Delegation of Informed Consent (Amendments to C&B)
008# Preventing Anti-Transgender Violence (Amendments to C&B)
009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
010# Covenants not to Compete (Amendments to C&B)
011# Mature Minor Consent to Vaccinations (Amendments to C&B)
012# Improving Body Donation Regulation (Amendments to C&B)
013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court (Amendments to C&B)
014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations (Amendments to C&B)

015# Opposing Mandated Reporting of People Who Question Their Gender Identity (Amendments to C&B)

016# Sexual and Gender Minority Populations in Medical Research (Amendments to C&B)

017# National Guidelines for Guardianship (Amendments to C&B)

018# Support for Requiring Investigations into Deaths of Children in Foster Care (Amendments to C&B)

019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes (Amendments to C&B)

020# Changes to E-5.7, "Physician-Assisted Suicide" (Amendments to C&B)

021# Health, In All Its Dimensions, Is a Basic Right (Amendments to C&B)

022# Opposition to Involuntary Civil Commitment for Substance Use Disorder (Amendments to C&B)

101 Health Hazards of High Deductible Insurance (A)

102 Use of HSAs for Direct Primary Care (A)

103 Health System Improvement Standards (A)

104 Adverse Impacts of Single Specialty Independent Practice Associations (A)

105 Payment for Brand Medications When the Generic Medication is Recalled (A)

106 Raising Medicare Rates for Physicians (A)

107 Investigate Medicare Part D - Insurance Company Upcharge (A)

108 Congressional Healthcare Proposals (A)

109 Part A Medicare Payment to Physicians (A)

110 Establishing Fair Medicare Payer Rates (A)

111 Practice Overhead Expense and the Site-of-Service Differential (A)

112 Health Care Fee Transparency (A)

113 Ensuring Access to Statewide Commercial Health Plans (A)

114 Ensuring Access to Nationwide Commercial Health Plans (A)

115 Safety of Drugs Approved by Other Countries (A)

116 Medicare for All (A)

117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use (A)

118 Pharmaceutical Pricing Transparency (A)

119# Returning Liquid Oxygen to Fee Schedule Payment (A)

120# Medicare Coverage of Hearing Aids (A)

121# Maintenance Hemodialysis for Undocumented Persons (A)

122# Reimbursement for Telemedicine Visits (A)

123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder (A)

124# Increased Affordability and Access to Hearing Aids and Related Care (A)

125# Mitigating the Negative Effects of High-Deductible Health Plans (A)

126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies (A)

127# Eliminating the CMS Observation Status (A)

201 Assuring Patient Access to Kidney Transplantation (B)

202 Reducing the Hassle Factor in Quality Improvement Programs (B)

203 Medicare Part B and Part D Drug Price Negotiation (B)

204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs (B)

205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary (B)

206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade (B)

207 Direct-to-Consumer Genetic Tests (B)
208 Repeal or Modification of the Sunshine Act (B)
209 Mandates by ACOs Regarding Specific EMR Use (B)
210 Air Ambulances (B)
211 Use of FAIR Health (B)
212 Pharmacy Benefit Managers (B)
213 Financial Penalties and Clinical Decision-Making (B)
214 The Term Physician (B)
215 Reimbursement for Health Information Technology (B)
216 Eliminate the Word Provider from Healthcare Contracts (B)
217 Medicare Vaccine Billing (B)
218 Payment for Medications Used Off Label for Treatment of Pain (B)
219 Medical Marijuana License Safety (B)
220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders (B)
221 Extending Medicaid Coverage to 12-Months Postpartum (B)
222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads (B)
223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record (B)
224 Extending Pregnancy Medicaid to One Year Postpartum (B)
225 DACA in GME (B)
226 Physician Access to Their Medical and Billing Records (B)
227 Controlled Substance Management (B)
228 Truth in Advertising (B)
229 Clarification of CDC Opioid Prescribing Guidelines (B)
230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes (B)
231# Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (B)
232# COPD National Action Plan (B)
233# GME Cap Flexibility (B)
234# Improved Access to Non-Opioid Therapies (B)
235# Prescription Coverage of the Lidocaine Transdermal Patch (B)
236# Support for Universal Basic Income Pilot Studies (B)
237# Opportunities in Blockchain for Healthcare (B)
238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis (B)
239# Improving Access to Medical Care Through Tax Treatment of Physicians (B)
240# Formation of Collective Bargaining Workgroup (B)
241# Facilitation of Research with Medicare Claims Data (B)
301 American Board of Medical Specialties Advertising (C)
302 The Climate Change Lecture for US Medical Schools (C)
303 Graduate Medical Education and the Corporate Practice of Medicine (C)
304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs (C)
305 Lack of Support for Maintenance of Certification (C)
306 Interest Rates and Medical Education (C)
307 Mental Health Services for Medical Students (C)

308 MOC Moratorium (C)

309 Promoting Addiction Medicine During a Time of Crisis (C)

310 Mental Health Care for Medical Students (C)

311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure (C)

312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians (C)

313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows (C)

314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes (C)

315 Scholarly Activity by Resident and Fellow Physicians (C)

316 Medical Student Debt (C)

317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities (C)

318 Rural Health Physician Workforce Disparities (C)

319# Adding Pipeline Program Participation Questions to Medical School Applications (C)

320# Opioid Education in Medical Schools (C)

321# Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession (C)

322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools (C)

401 Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies (D)

402 Bullying in the Practice of Medicine (D)

403 White House Initiative on Asian Americans and Pacific Islanders (D)

404 Shade Structures in Public and Private Planning and Zoning Matters (D)

405 Gun Violence Prevention: Safety Features (D)

406 Reduction in Consumption of Processed Meats (D)

407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents (D)

408 Banning Edible Cannabis Products (D)

409 Addressing the Vaping Crisis (D)

410 Reducing Health Disparities Through Education (D)

411 AMA to Analyze Benefits / Harms of Legalization of Marijuana (D)

412 Regulating Liquid Nicotine and E-Cigarettes (D)

413 End the Epidemic of HIV Nationally (D)

414 Patient Medical Marijuana Use in Hospitals (D)

415 Distracted Driving Legislation (D)

416 Non-Medical Exemptions from Immunizations (D)

417 Improved Health in the United States Prison System Through Hygiene and Health Educational Programming for Inmates and Prison Staff (D)

418 Eliminating the Death Toll from Combustible Cigarettes (D)

419 Universal Access for Essential Public Health Services (D)

420 Coordinating Correctional and Community Healthcare (D)

421 Contraception for Incarcerated Women (D)

422 Promoting Nutrition Education Among Healthcare Providers (D)

423# Mandatory Immunizations for Asylum Seekers (D)

424# Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury (D)

425# Distracted Driver Education and Advocacy (D)
426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities (D)
427# Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled (D)
428# Dangers of Vaping (D)
429# Support for Children of Incarcerated Parents (D)
430# Compassionate Release for Incarcerated Patients (D)
431# Eliminating Recommendations to Restrict Dietary Cholesterol and Fat (D)
432# Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals (D)
433# Transformation of Rural Community Public Health Systems (D)
434# Change in Marijuana Classification to Allow Research (D)
501 USP 800 (E)
502 Destigmatizing the Language of Addiction (E)
503 Addressing Healthcare Needs of Children of Incarcerated Parents (E)
504 Screening, Intervention, and Treatment for Adverse Childhood Experiences (E)
505 Glyphosate Studies (E)
506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements (E)
507 Removing Ethylene Oxide as a Medical Sterilant from Healthcare (E)
508 Benzodiazepine and Opioid Warning (E)
509 Addressing Depression to Prevent Suicide Epidemic (E)
510 The Intracranial Hemorrhage Anticoagulation Reversal Initiative (E)
511 Mandating Critical Congenital Heart Defect Screening in Newborns (E)
512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients (E)
513 Determining Why Infertility Rates Differ Between Military and Civilian Women (E)
514 Opioid Addiction (E)
515 Reversing Opioid Epidemic (E)
516 Alcohol Consumption and Health (E)
517# Compounding (E)
518# Chemical Variability in Pharmaceutical Products (E)
519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment (E)
520# Substance Use During Pregnancy (E)
521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter (E)
522# Improved Deferral Periods for Blood Donors (E)
523# Availability and Use of Low Starting Opioid Doses (E)
524# Availability of Naloxone Boxes (E)
525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents (E)
526# Trauma-Informed Care Resources and Settings (E)
527# Increasing the Availability of Bleeding Control Supplies (E)
528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing (E)
529# Adverse Impacts of Delaying the Implementation of Public Health Regulations (E)
530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program (E)
601 AMA Policy Statement with Editorials (F)
602 Expectations for Behavior at House of Delegates Meetings (F)
603 Creation of an AMA Election Reform Committee (F)

604 Engage and Collaborate with The Joint Commission (F)
605 State Societies and the AMA Litigation Center (F)
606 Investigation into Residents, Fellows and Physician Unions (F)
607 Re-establishment of National Guideline Clearinghouse (F)
608 Financial Protections for Doctors in Training (F)
609 Update to AMA Policy H-525.998, "Women in Organized Medicine" (F)
610 Mitigating Gender Bias in Medical Research (F)
611# Election Reform (F)
612# Request to AMA for Training in Health Policy and Health Law (F)
613# Language Proficiency Data of Physicians in the AMA Masterfile (F)
614# Racial and Ethnic Identity Demographic Collection by the AMA (F)
615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership (F)
616# TIME'S UP Healthcare (F)
617# Disabled Physician Advocacy (F)
701 Coding for Prior Authorization Obstacles (G)
702 Peer Support Groups for Second Victims (G)
703 Preservation of the Patient-Physician Relationship (G)
704 Prior Authorization Reform (G)
705 Physician Requirements for Comprehensive Stroke Center Designation (G)
706 Hospital Falls and "Never Events" - A Need for More in Depth Study (G)
707 Cost of Unpaid Patient Deductibles on Physician Staff Time (G)
708# Access to Psychiatric Treatment in Long Term Care (G)
709# Promoting Accountability in Prior Authorization (G)
710# Council for Affordable Quality Healthcare Attestation (G)
711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs (G)
712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives (G)

Contained in the Handbook Addendum

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- AMA member.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.

SEATING ALLOCATION – 2019 ANNUAL MEETING

ADDICTION MEDICINE - 2
American Society of Addiction Medicine (ASAM) – 2

AMDA – 2
AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) – 2

AMGA - 4
American Medical Group Association (AMGA) - 4

ANESTHESIOLOGY - 10
American Society of Anesthesiologists (ASA) - 10
- Trustee (McDade) - 1
- Former Board Chair (Patchin) - 1
- Delegates - 7
- Resident and Fellow Section Delegate - 1

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 10
American College of Cardiology (ACC) - 6
American Society of Echocardiography (ASE) - 2
Heart Rhythm Society (HRS) - 1
Society for Cardiovascular Angiography and Interventions (SCAI) - 1

CHEST PHYSICIANS - 3
American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 2
Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 9
American Academy of Dermatology (AAD) - 4
American College of Mohs Surgery (ACMS) - 1
American Society for Dermatologic Surgery (ASDS) - 2
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

EMERGENCY MEDICINE - 9
American College of Emergency Physicians (ACEP) - 9
- Former President (Stack) - 1
- Delegates - 7
- Resident and Fellow Section Delegate - 1

ENDOCRINOLOGY - 6
American Association of Clinical Endocrinologists (AACE) - 2
American Soc for Reproductive Medicine (ASRM) - 2
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 17
American Academy of Family Physicians (AAFP) - 17
- Former Board Chair (Langston) - 1
- Delegates - 16

GASTROENTEROLOGY - 6
American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 2

GERIATRIC MEDICINE - 2
American Geriatric Society (AGS) – 2

GREAT LAKES - 75
Illinois - 21
- Trustee (Kobler) - 1
- Delegates - 12
- Medical Student Regional Delegate- 1
- Resident and Fellow Section Delegate – 1
- American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) - 1
- American College of Legal Medicine (ACLM) - 1
- American Coll of Radiation Oncology (ACRO) - 1
- American Med Women's Association (AMWA) - 1
- North American Neuro-Ophthalmology Society (NANOS) - 1
- Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1

Indiana - 7
- Former Board Chair (Steen) - 1
- Delegates – 5
- Medical Student Regional Delegate- 1

Michigan - 15
- Trustee (Mukkamala) - 1
- Delegates - 13
- Medical Student Regional Delegate - 1

Ohio - 13
- Delegates - 11
- Medical Student Regional Delegates - 1
- Resident and Fellow Section Delegate - 1

Pennsylvania - 19
- Former President (Gurman) - 1
- Delegates - 14
- Medical Student Regional Delegate- 1
- Resident and Fellow Section Delegate - 1
- American Association of Physicians of Indian Origin (AAPIO) - 1
- American College of Medical Genetics and Genomics (ACMGG) - 1

HEART OF AMERICA - 9
Kansas - 3
Missouri – 6
- Delegates - 5
- Medical Student Regional Delegate- 1

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 2
Society of Hospital Medicine (SHM) - 2

INFECTIOUS DISEASE - 3
Infectious Diseases Society of America (IDSA) - 3
- Delegates - 2
- Resident and Fellow Section Delegate - 1

INTERNAL MEDICINE - 24
American College of Physicians (ACP) – 24
- Trustee (Fryhofer) – 1
- Delegates – 23

MOBILITY CAUCUS - 22
American Acad of Orthopaedic Surgeons (AAOS) - 5
American Academy of Physical Med & Rehabilitation (AAPMR) - 2
American Association for Hand Surgery (AAHS) - 1
Amer Assoc of Neuromuscular & Electrodiagnostic Med (AANEM) - 1
American Clinical Neurophysiology Soc (ACNS) - 1
American College of Occupational & Environmental Med (ACOEM) - 1
American College of Rheumatology (ACRh) - 2
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) - 2
- Delegate - 1
- Resident and Fellow Section Delegate - 1

International Academy of Independent Medical Evaluators (IAIME) - 1
International Society for the Advancement of Spine Surgery (ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES - 29
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 1
American Academy of Neurology (AAN) - 4
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 2
American Association of Neurological Surgeons (AANS) - 4
- Former President (Carmel) - 1
- Delegates – 2
- Resident and Fellow Section Delegate - 1

American Psychiatric Association (APA) - 9
- Delegates - 8
- Resident and Fellow Section Delegate – 1

American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 1
GLMA – 1
North American Neuromodulation Society (NANS) - 1
Spine Intervention Society (SIS) - 1

NEW ENGLAND - 31
Connecticut - 7
- Delegates - 4
- Medical Student Regional Delegates- 3

Maine - 3
- Former President (McAfee) - 1
- Delegates - 2

Massachusetts - 16
- Trustee (Motta) -1
- Delegates - 13
- Medical Student Regional Delegate- 1
- American Soc of Abdominal Surgeons (ASAS) - 1

New Hampshire - 2
- Trustee (Tuttle) - 1
- Delegate - 1

Rhode Island - 2
Vermont – 1

NEW YORK - 28
Former President (Nielsen) - 1
Former Board Chair (Cady) - 1
Delegates - 20
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 1
Society of Interventional Radiology (SIR) - 1

NORTH CENTRAL - 13
Iowa - 3
Minnesota – 6
- Delegates - 5
- Medical Student Regional Delegate- 1

Nebraska - 2
North Dakota - 1
South Dakota - 1

OBSTETRICIANS AND GYNECOLOGISTS - 16
American Association of Gynecologic Laparoscopists (AAGL) - 2
American College of Obstetricians and Gynecologists (ACOG) - 14
- Delegates - 13
- Resident and Fellow Section Delegate - 1

ONCOLOGY - 4
American Society of Clinical Oncology (ASCO) – 4
- Delegates - 3
- Resident and Fellow Section Delegate - 1

PACWEST CONFERENCE - 72
Alaska - 1
Arizona - 8
- Delegates - 5
- Medical Student Regional Delegate- 1
- American Institute of Ultrasound in Medicine (AIUM) - 2

California - 32
- Trustee (Ribeira) - 1
- Former Presidents (Bristow, Corlin, Plested) - 3
- Delegates - 23
- Medical Student Regional Delegate - 1
- Resident and Fellow Section Delegates - 2
- American Soc for Radiation Oncology (ASRO) – 2
  - Delegate - 1
  - Resident and Fellow Section Delegate - 1

Colorado - 8
- Former President (Lazarus) - 1
- Delegates - 5
- Medical Student Regional Delegate- 1
- Obesity Medicine Association (OMA) - 1

Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 4
- Delegates - 2
- Medical Student Regional Delegate- 1
- Resident and Fellow Section Delegate - 1

New Mexico - 3
- Delegates - 2
- American Academy of Allergy, Asthma & Immunology (AAAAI) – 1

PACWEST CONFERENCE (CONT'D)
Oregon - 3
- Former President (Reardon) - 1
- Delegates - 2

Utah - 4
- Former Presidents (A. Nelson, J. Nelson) - 2
- Delegates - 2

Washington - 4
Wyoming – 1

PATHOLOGY - 11
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
- Delegates - 3
- Resident and Fellow Section Delegate - 1

National Association of Medical Examiners (NAME) - 1
United States and Canadian Academy of Pathology (USCAP) – 2

PEDIATRICS - 6
American Academy of Pediatrics (AAP) - 6
- Delegates - 5
- Resident and Fellow Section Delegate - 1

PREVENTIVE MEDICINE - 6
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
- Delegate - 1
- Resident and Fellow Section Delegate - 1

American College of Medical Quality (ACMQ) - 1
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 12
American College of Radiology (ACR) – 8
- Delegates - 7
- Resident and Fellow Section Delegate - 1

American Roentgen Ray Society (ARRS) – 3
Association of University Radiologists (AUR) - 1

RSNA - 3
Radiological Society of North America (RSNA) – 3

SECTIONS - 11
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
- Trustee (Sarma) - 1
- Delegate – 1

Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) - 1
Resident and Fellow Section (RFS) - 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 1
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 122
Alabama - 5
- Delegates - 4
- Medical Student Regional Delegate- 1

Arkansas - 4
- Trustee (Ferguson) – 1
- Delegates - 3

Delaware - 2
- Former Board Chair (Permut) – 1
- Delegate - 1

District of Columbia - 4
- Former Board Chair (Scalettar) - 1
- Delegates - 2
- Medical Student Regional Delegate- 1

Florida - 22
- Former Presidents (Coble, Wilson) - 2
- Delegates - 14
- Medical Student Regional Delegate- 2
- Resident and Fellow Section Delegates - 2
- American Vein and Lymphatic Society (AVLS) - 1
- The Triological Society (TS) - 1

Georgia - 5
Kentucky - 5
- Former President (Hoven) - 1
- Delegates (minus Vice Speaker) - 5

Louisiana - 8
- Former Presidents (Johnson, Palmisano) - 2
- Delegates - 5
- Medical Student Regional Delegate- 1

Maryland - 9
- Trustee (Edwards) - 1
- Former Board Chair (Lewers) - 1
- Delegates - 5
- Acad of Physicians in Clinical Research (APCR) - 1
- Renal Physicians Association (RPA) - 1

Mississippi - 5
- Former President (Hill) - 1
- Delegates - 3
- American Osteopathic Association (AOA) - 1

New Jersey - 9
- Delegates - 8
- Medical Student Regional Delegate- 1

North Carolina - 7
- Trustee (Osbahr) - 1
- Delegates - 6

Oklahoma - 7
- Delegates - 4
- Medical Student Regional Delegate- 2
- Resident and Fellow Section Delegate - 1

Puerto Rico - 2
South Carolina – 9
- Trustee (Harmon) - 1
- Former President (Smoak) - 1
- Delegates - 5
- Medical Student Regional Delegate- 1
- American Society for Metabolic and Bariatric Surgery (ASMBS) - 1

Tennessee - 7
- Trustee (Williams) - 1
- Delegates - 5
- Medical Student Regional Delegate- 1

SOUTHEASTERN (CONT'D.)
Virginia - 10
- Former President (Wootton) - 1
- Delegates - 8
- Medical Student Regional Delegate- 1

West Virginia – 2

SURGEONS - 47
American Academy of Cosmetic Surgery (AACS) - 1
American Academy of Ophthalmology (AAO) - 5
- Delegates - 4
- Resident and Fellow Section Delegate - 1

American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) – 13
American Society for Aesthetic Plastic Surgery (ASAPS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 1
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 1
American Society of General Surgeons (ASGS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) - 2
American Society of Retina Specialists (ASRS) - 1
American Society of Transplant Surgeons (ASTS) - 1
Contact Lens Assoc of Ophthalmologists (CLAO) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2
Society of Laparoendoscopic Surgeons (SLR) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 26
Former Presidents (Dickey, Rohack) - 2
Delegates (minus Speaker) - 20
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Allergy, Asthma and Immunology (ACAAI) - 1
International Society of Hair Restoration Surgery (ISHRS) – 1
National Medical Association (NMA) - 1

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 4
American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) - 3
- Delegates -2
- Resident and Fellow Section Delegate – 1

WISCONSIN - 8
- Former Board Chair (Flaherty) - 1
- Delegates - 5
- Resident and Fellow Section Delegate - 1
- Undersea & Hyperbaric Medical Society (UHMS) - 1

OFFICIAL OBSERVERS - 28
Accreditation Association for Ambulatory Health Care
Alliance for Continuing Education in the Health Professions
Alliance for Regenerative Medicine
Ambulatory Surgery Center Association
American Academy of Physician Assistants
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Health Quality Association
American Hospital Association
American Nurses Association
American Podiatric Medical Association
American Public Health Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Commission on Graduates of Foreign Nursing Schools
Council of Medical Specialty Societies
Educational Commission for Foreign Medical Graduates
Federation of State Medical Boards
Federation of State Physician Health Programs
Medical Group Management Association
Medical Professional Liability Association
National Association of County and City Health Officials
National Commission on Correctional Health Care
National Council of State Boards of Nursing
National Indian Health Board
Society for Academic Continuing Medical Education
US Pharmacopeia

TELLERS - 8

HOUSE OF DELEGATES · HYATT REGENCY CHICAGO (A-19)

Audience Left — **Audience Right**

STAGE

SPEAKER — VICE SPEAKER

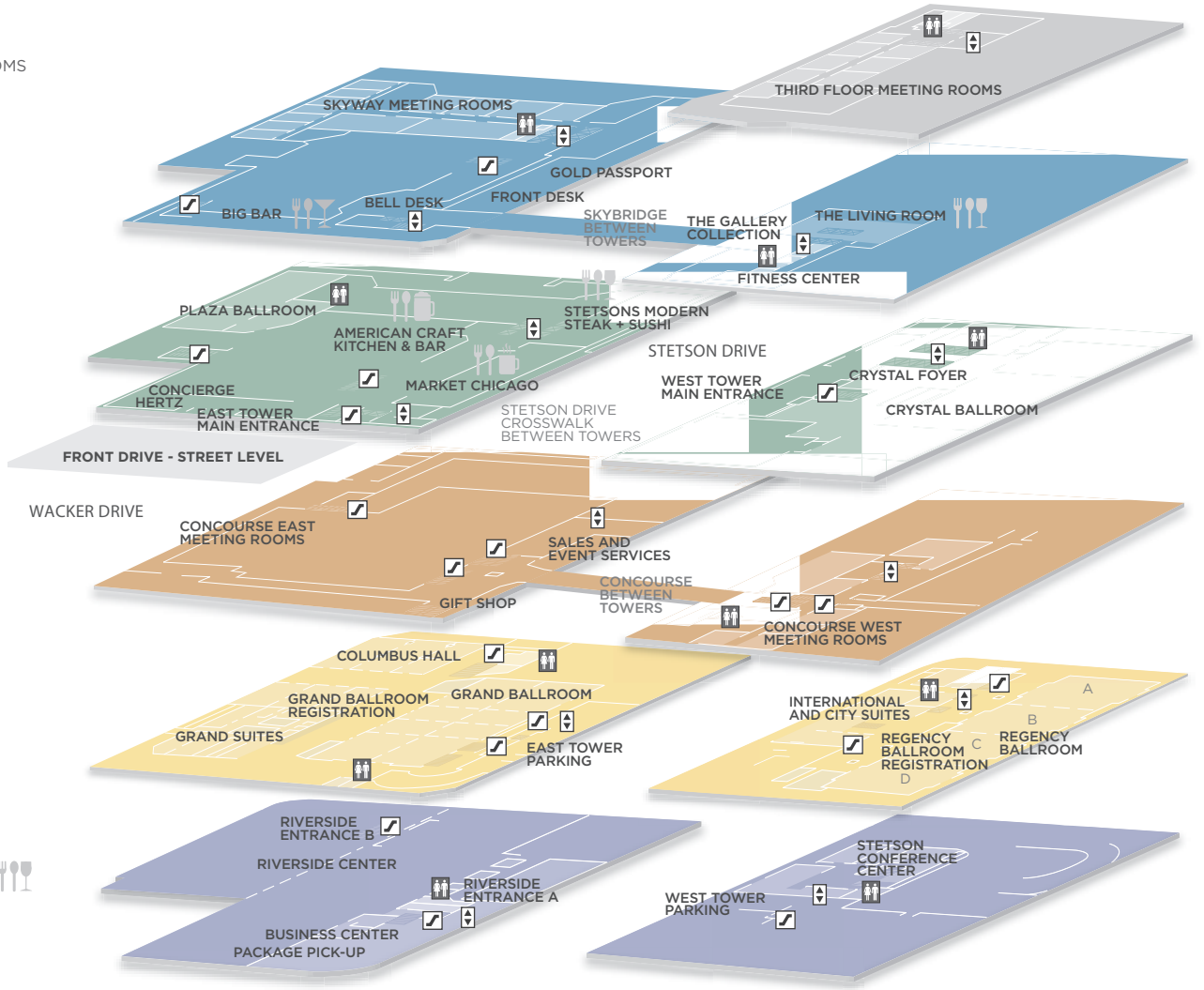
SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14
ROW			ILLINOIS (21)		INDIANA (7)		MICHIGAN (15)		OHIO (13)		PENNSYLVANIA (19)			
1	T	T											T	T
	ILLINOIS				INDIANA		MICHIGAN		OHIO			PENNSYLVANIA		
2														
	ILLINOIS				INDIANA		MICHIGAN		OHIO			PENNSYLVANIA		
3					Steen	IN student								
	ILLINOIS				MICHIGAN				OHIO			PENNSYLVANIA		
4	ACRO								OH student					
	ILLINOIS				MICHIGAN				OHIO			PENNSYLVANIA		
5	AAFPRS	IL student	IL resident	Kobler			MI student	Mukkamala	OH resident			PA student		ACMGG
	ILLINOIS					ONCOLOGY (4)				PENNSYLVANIA				
6	SNMMI	AMWA	ACLM	NANOS					ASCO resident	PA resident	Gurman			AAPIO
	NEUROSCIENCES (29)								SECTIONS (11)					
7	Carmel	AANS	AANS	AANS resident	CNS	AAN	AAN		Sarma	MSS	MAS	APS	RFS	WPS
	NEUROSCIENCES						WISCONSIN (8)		SECTIONS					
8	GLMA	SIS	NANS	AAPM	ASNI	AAN	AAN			YPS	OMSS	IPPS	IMG	SPS
	NEUROSCIENCES						WISCONSIN					TEXAS (26)		
9	AAPL	APA	APA	AACAP	AACAP	AAGP	AAGP	WI resident						
	NEUROSCIENCES				AMGA (4)		WISCONSIN		TEXAS					
10	AAHPM	APA	APA	APA			Flaherty	UHMS						
	NEUROSCIENCES				AMGA		HOSP MED (2)		TEXAS					
11	APA	APA	APA	APA resident					TX resident					
	KANSAS (3)			EMERGENCY MEDICINE (9)			ARS (1)		TEXAS					
12							ARS		TX student					
	MISSOURI (6)			EMERGENCY MEDICINE			SURGEONS (47)			TEXAS				
13						ACEP resident	ACS	ACS	ACS	Rohack	Dickey	ACAAI	ISHRS	NMA
	MISSOURI			EMERGENCY MEDICINE			SURGEONS							
14			MO student			Stack	ACS	ACS	ACS	ACS	ACS	ASAPS	AAPS	AACS
	SERVICES (6)						SURGEONS							
15	VA	PHS	NAVY	AMSUS	ARMY	AF	ACS	ACS	ACS	ACS	ACS	ASPS	ASPS	ASRMS
	CARDIOLOGY (10)						SURGEONS							
16	ACC	ACC	ACC	ACC	ASE	ASE		ASBS	ASCRS	ASGS	ASMS	AAOHNS	AAOHNS	AAOHNS
	THORACIC (2)		CARDIOLOGY				SURGEONS							
17			ACC	ACC	HRS	SCAI		ICSUS	SAGES	SAGES	CLAO	AAOA	ASTS	AATS
	CRITICAL CARE (2)		CHEST PHYSICIANS (3)		PREVENT MED		SURGEONS							
18						AAPHP	AAPHP resident	SLR	SLR	ASOPRS	ASCTRS	ASCTRS	STS	STS
	PATHOLOGY (11)			PREVENTIVE MEDICINE (6)			SURGEONS							
19	ASCP	ASCP	ASCP	AsMA	AAIM	ACMQ	ACPM	AAO resident	AAO	AAO	AAO	AAO	ASRS	SVS
	PATHOLOGY								HEMATOLOGY (2)		NEW HAMP (2)		RHODE ISL (2)	
20	USCAP	USCAP	NAME	ASC	CAP	CAP	CAP	CAP resident			Tuttle			
	GASTRO		RSNA (3)				MASSACHUSETTS (16)							
21	ACG	ACG												
	GASTROENTEROLOGY (6)				MOBILITY		MASSACHUSETTS						CT	
22	ASGE	ASGE	AGA	AGA	ASIPP	ASIPP resident	MA student							
	MOBILITY CAUCUS (22)						MASS		CONNECTICUT (7)					VT (1)
23	NASS	NASS	ISASS	IAIME	ACRh	ACRh	ASAS	Motta	CT student	CT student	CT student			
	MOBILITY CAUCUS							MAINE (3)			ENDOCRINOLOGY (6)			
24	AAOS	AAOS	AAOS	AAHS	ASSH	AOrA	AANEM	McAfee			AACE	AACE	ASRM	ASRM
	MOBILITY CAUCUS							ADDICTION (2)		INFECTIOUS DIS (3)			ENDO	
25	AAOS	AAOS	AOFAS	ACOEM	ACNS	AAPMR	AAPRM			IDSA resident			ES	ES
26	OFFICIAL OBSERVERS (28)													

SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14
ROW			PEDIATRICS (6)		FAMILY PHYSICIANS (17)			INTERNAL MEDICINE (24)			AMDA (2)			
1	T	T											T	T
	PEDIATRICS				FAMILY PHYSICIANS			INTERNAL MEDICINE						
2				AAP resident										
	FAMILY PHYSICIANS							INTERNAL MEDICINE						
3							Langston	Fryhofer						
	FAMILY PHYSICIANS				INTERNAL MEDICINE							OB/GYN (16)		
4												ACOG	ACOG	ACOG
	MISSISSIPPI (5)					UROLOGY (4)				OBSTETRICIANS AND GYNECOLOGISTS				
5				AOA	Hill	AACU	AUA resident	AUA	AUA	ACOG	ACOG	ACOG	ACOG	ACOG
	TENNESSEE (7)								OBSTETRICIANS AND GYNECOLOGISTS					
6						TN student	Williams		ACOG resident	ACOG	ACOG	ACOG	AAGL	AAGL
	MARYLAND (9)								OB/GYN		SLEEP MED (2)		GERIATRIC MED (2)	
7						APCR	RPA		ACOG	ACOG				
	ARKANSAS (4)				MD		IOWA (3)			NEBRASKA (2)		MINNESOTA		SD (1)
8				Ferguson	Edwards	Lewers								
	SOUTH CAROLINA (9)							GU (1)	VI (1)	MINNESOTA (6)				ND (1)
9						ASMBS	SC student			MN student				
	ALABAMA (5)					SC			RADIOLOGY (12)					
10					AL student	Smoak	Harmon		ARRS	ARRS	ARRS	ACR	ACR	ACR
	FLORIDA (22)								RADIOLOGY					
11						Coble	Wilson		ACR resident	ACR	ACR	ACR	ACR	AUR
	FLORIDA							ANESTHESIOLOGY (10)						
12						FL student	FL student	McDade	Patchin					
	FLORIDA							ANESTHESIOLOGY			DERMATOLOGY (9)			
13					AVLS	TS	FL resident	FL resident	ASA resident			ACMS	ASD	SID
	WEST VIRGINIA (2)		DISTRICT OF COLUMBIA (4)				NEW YORK (28)				DERMATOLOGY			
14					DC student	Scalettar					AAD	AAD	AAD	AAD
	NORTH CAROLINA (7)						NEW YORK					DERMATOLOGY		
15							Osbahr	NY resident					ASDS	ASDS
	OKLAHOMA (7)						NEW YORK							
16					OK resident	OK student	OK student	NY resident						
	LOUISIANA (8)						NEW YORK							
17						LA student	NY student	ASN						
	PUERTO RICO (2)		DELAWARE (2)		LOUISIANA		NEW YORK			ARIZONA (8)				
18				Permut	Palmisano	Johnson	ACNM	SIR	Cady	Nielsen	AZ student			
	NEW JERSEY (9)						CALIFORNiA (32)			ARIZONA				AK (1)
19										AIUM	AIUM			
	VIRGINIA (10)			NEW JERSEY				CALIFORNIA						
20						NJ student								
	VIRGINIA							CALIFORNIA						
21						VA student	Wootton					ASRO resident	ASRO	
	KENTUCKY (5)					CALIFORNIA					COLORADO (8)			
22					Hoven	CA student					Lazarus			
	GEORGIA (5)					CALIFORNIA					COLORADO			
23						CA resident					CO student			OMA
	WY (1)	WASHINGTON (4)				CALIFORNIA					MT (1)	ID (1)	HAWAII (2)	
24						CA resident	Ribeira	Bristow	Corlin	Plested				
	UTAH (4)				OREGON (3)			NEW MEXICO (3)			NEVADA (4)			
25			A. Nelson	J. Nelson			Reardon	AAAAI			NV student	NV resident		
26	OFFICIAL OBSERVERS (28)													

HYATT REGENCY CHICAGO
GUEST MAP

WELCOME TO HYATT REGENCY CHICAGO. Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 4460.

- ACAPULCO — West Tower, Ballroom Level
- ADDAMS — West Tower, Third Floor
- AMERICAN CRAFT KITCHEN & BAR — East Tower, Lobby Level
- ATLANTA — West Tower, Ballroom Level
- BELL DESK — East Tower, Skyway Level
- BIG BAR — East Tower, Skyway Level
- BURNHAM — West Tower, Third Floor
- BUSINESS CENTER, PACKAGE ROOM — East Tower, Exhibit Level
- COLUMBIAN — West Tower, Concourse Level
- COLUMBUS HALL (ROOMS A-L) — East Tower, Ballroom Level
- COMISKEY — West Tower, Concourse Level
- CONCOURSE WEST MEETING ROOMS — West Tower, Concourse Level
- CONCIERGE — East Tower, Lobby Level
- CRYSTAL BALLROOM — West Tower, Lobby Level
- DUSABLE — West Tower, Third Floor
- EAST TOWER MAIN ENTRANCE — East Tower, Lobby Level
- EAST TOWER PARKING — East Tower, Ballroom Level
- FIELD — West Tower, Third Floor
- FITNESS CENTER — West Tower, Skyway Level
- FRONT DESK — East Tower, Skyway Level
- THE GALLERY COLLECTION — West Tower, Skyway Level
  Gallery Boardrooms 1, 2, 3, 4, & 5
- GIFT SHOP — East Tower, Concourse Level
- GOLD COAST — West Tower, Concourse Level
- GOLD PASSPORT — East Tower, Skyway Level
- GRAND BALLROOM — East Tower, Ballroom Level
- GRAND SUITES — East Tower, Ballroom Level
- HAYMARKET — West Tower, Concourse Level
- HERTZ — East Tower, Lobby Level
- HONG KONG — West Tower, Ballroom Level
- HORNER — West Tower, Third Floor
- CONCOURSE EAST MEETING ROOMS — East Tower, Concourse Level
  Michigan Meeting Rooms
  Michigan 2 Meeting Rooms
  Michigan 3 Meeting Rooms
  Monroe Meeting Rooms
- THE LIVING ROOM — West Tower, Skyway Level
- MARKET CHICAGO — East Tower, Lobby Level
- McCORMICK — West Tower, Third Floor
- NEW ORLEANS — West Tower, Ballroom Level
- OGDEN — West Tower, Third Floor
- PACKAGE PICK-UP — East Tower, Exhibit Level
- PICASSO — West Tower, Concourse Level
- PLAZA BALLROOM — East Tower, Lobby Level
- REGENCY BALLROOM — West Tower, Ballroom Level
- RIVERSIDE CENTER — East Tower, Exhibit Level
- SALES AND EVENT SERVICES — East Tower, Concourse Level
- SAN FRANCISCO — West Tower, Ballroom Level
- SANDBURG — West Tower, Third Floor
- SKYWAY MEETING ROOMS — East Tower, Skyway Level
- SOLDIER FIELD — West Tower, Concourse Level
- STETSON CONFERENCE CENTER — West Tower, Exhibit Level
- STETSONS MODERN STEAK + SUSHI — East Tower, Lobby Level
- TORONTO — West Tower, Ballroom Level
- WATER TOWER — West Tower, Concourse Level
- WEST TOWER PARKING — West Tower, Exhibit Level
- WRIGHT — West Tower, Third Floor
- WRIGLEY — West Tower, Concourse Level



ESCALATORS, ELEVATORS AND RESTROOMS are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

CROSSING BETWEEN TOWERS: Cross between towers via the Skybridge or the Concourse. You may also cross from the lobby level via the crosswalk on Stetson Drive.

ELEVATORS
ESCALATORS AND STAIRS
RESTROOMS

REFERENCE COMMITTEE ROOM ASSIGNMENTS
SUNDAY, JUNE 9

8:30AM – Noon

Reference Committee A	Regency Ballroom A
Reference Committee B	Regency Ballroom B
Reference Committee C	Regency Ballroom C
Reference Committee E	Regency Ballroom D
Reference Committee F	Grand Ballroom

1:30pm- 5pm

Constitution & Bylaws	Regency Ballroom C
Reference Committee D	Regency Ballroom D
Reference Committee G	Regency Ballroom A

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (A-19)

Reference Committee on Amendments to Constitution and Bylaws
William Reha, MD, MBA, Virginia, Chair
Robert C. Gibbs, MD, Kansas
Bassam H. Nasr, MD, Michigan
Jill M. Owens, MD, Pennsylvania
Scott Pasichow, MD, American College of Emergency Physicians, Sectional Resident
Abdul Rehman, MD, New York*
Richard S. Wilbur, MD, American College of Legal Medicine

Reference Committee A (Medical Service)
John M. Montgomery, MD, Florida, Chair
William C. Davison, MD, American Academy of Neurology*
Gregory M. Fuller, MD, Texas*
Russell C. Libby, MD, Virginia, Integrated Physician Practice Section
Loralie D. Ma, MD, Maryland
Kevin D. Nohner, MD, Nebraska
Laura Shea, MD, Illinois

Reference Committee B (Legislation)
Charles Rothberg, MD, New York, Chair
Jenni Bartlotti-Telesz, MD, American Society of Anesthesiologists*
Michael B. Hoover, MD, Indiana
Steve Y. Lee, MD, American Society of Clinical Oncology*
Michael Medlock, MD, Massachusetts*
Chris Pittman, MD, American Vein and Lymphatic Society
Stephen J. Rockower, MD, Maryland

Reference Committee C (Medical Education)
Nicole Riddle, MD, US and Canadian Academy of Pathology, Chair
Ricardo Correa, MD, Arizona*, International Medical Graduate Section
Albert M. Kwan, MD, American Society of General Surgeons
George M. Lange, MD, Wisconsin
Elizabeth U. Parker, MD, Washington*, Sectional Resident
Richard Pieters, Jr., MD, Massachusetts
Charles W. Van Way, III, MD, Missouri

Reference Committee D (Public Health)
Diana E. Ramos, MD, American College of Obstetricians and Gynecologists, Chair
Robert L. Dannenhoffer, MD, Oregon
James D. Felsen, MD, West Virginia*
Vito Imbasciani, MD, California
Shilpen A. Patel, MD, American Society for Radiation Oncology
Rohan Rastogi, Massachusetts*, Regional Medical Student
Kevin Taubman, MD, Oklahoma*

Reference Committee E (Science and Technology)
Leslie H. Secrest, MD, Texas, Chair
William E. Bowman, Jr., MD, North Carolina
Wayne C. Hardwick, MD, Nevada
Shane Hopkins, MD, American Society for Radiation Oncology*
Shawn C. Jones, MD, Kentucky*
Nancy L. Mueller, MD, New Jersey
Raymond B. Wynn, MD, American College of Radiology

Reference Committee F (AMA Finance; AMA Governance)
Greg Tarasidis, MD, South Carolina, Chair
Michael D. Chafty, MD, Michigan
Melissa J. Garretson, MD, American Academy of Pediatrics*
Jerry L. Halverson, MD, American Psychiatric Association
Candace E. Keller, MD, American Society of Anesthesiologists
A. Lee Morgan, MD, Colorado
Ann R. Stroink, MD, Congress of Neurological Surgeons

Reference Committee G (Medical Practice)
Rodney L. Trytko, MD, Washington, Chair
Michael D. Bishop, MD, American College of Emergency Physicians
Paul D. Bozyk, MD, Michigan*
Alex Malter, MD, Alaska
Sterling Ransone, Jr., MD, Virginia*
Stephen Tharp, MD, Indiana
Brett E. Youngerman, MD, American Association of Neurological Surgeons, Sectional Resident

Committee on Rules and Credentials
H. Timberlake Pearce, Jr., MD, South Carolina, Chair
Patricia L. Austin, MD, California
Oran Lee Berkenstock, MD, Tennessee*
Jenny Boyer, MD, Oklahoma*
Madelyn E. Butler, MD, Florida
Kenneth M. Certa, MD, American Psychiatric Association
Robert H. Emmick, Jr., MD, Texas*

Chief Teller
Billie L. Jackson, MD, Georgia

** Alternate Delegate*

2019 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the Annual Meeting of the House of Delegates in Chicago, Illinois, June 8-12, 2019.

The House of Delegates will convene at 2 p.m. on June 8, at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4
Alaska 1
Arizona 5
Arkansas 3
California 23
Colorado 5
Connecticut 4
Delaware 1
District of Columbia 2
Florida 14
Georgia 5
Guam 1
Hawaii 2
Idaho 1
Illinois 12
Indiana 5
Iowa 3
Kansas 3
Kentucky 5
Louisiana 5
Maine 2
Maryland 5
Massachusetts 13
Michigan 13
Minnesota 5
Mississippi 3
Missouri 5
Montana 1
Nebraska 2
Nevada 2
New Hampshire 1
New Jersey 8
New Mexico 2
New York 20
North Carolina 6
North Dakota 1
Ohio 11
Oklahoma 4
Oregon 2
Pennsylvania 14
Puerto Rico 2
Rhode Island 2
South Carolina 5
South Dakota 1
Tennessee 5
Texas 20
Utah 2
Vermont 1
Virgin Islands 1
Virginia 8
Washington 4
West Virginia 2
Wisconsin 5
Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA – The Society of Post-Acute and Long-Term Care Medicine 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology 4
American Academy of Family Physicians 16
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology - Head and Neck Surgery 3
American Academy of Pediatrics 5
American Academy of Physical Med. & Rehabilitation 2
American Academy of Sleep Medicine 2
American Association for Geriatric Psychiatry 2
American Association of Clinical Endocrinologists 2
American Association of Gynecologic Laparoscopists 2
American Association of Neurological Surgeons 2
American College of Cardiology 6
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 7
American College of Gastroenterology 2
American College of Obstetricians and Gynecologists 13
American College of Physicians 23
American College of Radiology 7
American College of Rheumatology 2
American College of Surgeons 13
American Gastroenterological Association 2
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Medical Group Association 4
American Psychiatric Association 8
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 2
American Society for Gastrointestinal Endoscopy 2
American Society for Reproductive Medicine 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 7
American Society of Cataract and Refractive Surgery 2
American Society of Clinical Oncology 3
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Plastic Surgeons 2
American Thoracic Society 2
American Urological Association 2
College of American Pathologists 3
Infectious Diseases Society of America 2
North American Spine Society 2
Radiological Society of North America 3
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 2
Society of Laparoendoscopic Surgeons 2
Society of Thoracic Surgeons 2
The Endocrine Society 2
United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (70) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	283
National Medical Specialty Societies	281
Professional Interest Medical Associations	2
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	28
Resident and Fellow Delegate Representatives	28
Sections	10
Services	5
Total Delegates	**640**

Registration facilities will be maintained at the Hyatt Regency Chicago in the Grand Ballroom Foyer.

Barbara L. McAneny, MD
President

Susan R. Bailey, MD
Speaker, House of Delegates

Russell W.H. Kridel, MD
Secretary

2018-2019

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Barbara L. McAneny ..... Albuquerque, New Mexico
President-Elect - Patrice A. Harris..... Atlanta, Georgia
Immediate Past President - David O. Barbe ..... Mountain Grove, Missouri
Secretary - Russell W.H. Kridel .....Houston, Texas
Speaker, House of Delegates - Susan R. Bailey .....Fort Worth, Texas
Vice Speaker, House of Delegates - Bruce A. Scott..... Louisville, Kentucky

Willarda V. Edwards (2020).....Baltimore, Maryland
Jesse M. Ehrenfeld, *Chair-Elect* (2022) ..... Nashville, Tennessee
E. Scott Ferguson (2022).....West Memphis, Arkansas
Sandra A. Fryhofer (2022)..... Atlanta, Georgia
Gerald E. Harmon (2021) ..... Pawleys Island, South Carolina
William E. Kobler (2020).....Rockford, Illinois
William A. McDade (2020).....Metairie, Louisiana
Mario E. Motta (2022).....Salem, Massachusetts
S. Bobby Mukkamala (2021)..... Flint, Michigan
Albert J. Osbahr, III (2019) .....Hickory, North Carolina
Jack Resneck, Jr., *Chair* (2022)..... San Rafael, California
Ryan J. Ribeira (2019).....Mountain View, California
Karthik V. Sarma (2019) .....Los Angeles, California
Georgia A. Tuttle (2019) ..... Lebanon, New Hampshire
Kevin W. Williams (2020) ..... Nashville, Tennessee

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS

Jerome C. Cohen, Chair, Loch Sheldrake, New York (2021); Patricia L. Austin, Vice Chair, Alamo, California (2022); Ariel Anderson, San Diego, California (Resident) (2021); Madelyn E. Butler, Tampa, Florida (2022); Pino D. Colone, Howell, Michigan (2020); Kieran McAvoy, Brookfield, Wisconsin (Student) (2019); Kevin C. Reilly, Sr., Elizabethtown, Kentucky (2022); Colette R. Willins, Westlake, Ohio (2019).
Ex Officio, without vote: Susan R. Bailey, Fort Worth, Texas; Bruce A. Scott, Louisville, Kentucky.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

James E. Sabin, Boston, Massachusetts, Chair (2019); Kathryn L. Moseley, Ann Arbor, Michigan, Vice-Chair (2020); Kimberly A. Chernoby, Indianapolis, Indiana (Resident) (2021); David Fleming, Columbia, Missouri (2024); Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Alexander M. Rosenau, Allentown, Pennsylvania (2022); Lauren Schleimer, Cambridge, Massachusetts (Student) (2019); Peter A. Schwartz, Reading, Pennsylvania (2023); Monique A. Spillman, Dallas, Texas (2021).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION

Willie Underwood, III, Buffalo, New York, Chair (2019); David T. Tayloe, Jr., Goldsboro, North Carolina, Vice Chair (2019); David H. Aizuss, Encino, California (2019); Vijaya L. Appareddy, Chattanooga, Tennessee (2019); Hans C. Arora, Cleveland Heights, Ohio (Resident) (2019); Mary S. Carpenter, Winner, South Dakota (2019); Gary W. Floyd, Keller, Texas (2019); Linda B. Ford, Bellevue, Nebraska (AMPAC Observer) (2019); Marilyn J. Heine, Dresher, Pennsylvania (2019); Beth Irish, Bend, Oregon (Alliance Liaison) (2019); Tripti C. Kataria, Chicago, Illinois (2019); Ajeet Singh, Boston, Massachusetts (Student) (2019); Heather A. Smith, New York, New York (2019); Marta J. Van Beek, Iowa City, Iowa (2019).
Secretary: George Cox, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Alfred Herzog, Hartford, Connecticut, Chair (2019); James Goodyear, North Wales, Pennsylvania, Vice Chair (2021); Michelle Berger, Austin, Texas (2022); Edmond Cabbabe, St. Louis, Missouri (2021); Clarence Chou, Milwaukee, Wisconsin (2020); J. Steven Ekman, St. Louis, Missouri (Student) (2019); Matthew Lecuyer, Providence, Rhode Island (Resident) (2019); Glenn A. Loomis, LaGrangeville, New York (2019); Shannon Pryor, Washington, District of Columbia (2020); Gary Thal, Northbrook, Illinois (2021).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Carol D. Berkowitz, Torrance, California, Chair (2019); Jacqueline A. Bello, Bronx, New York, Chair-Elect (2021); Lynne M. Kirk, Dallas, Texas (2019); Rohit Abraham, East Lansing, Michigan (Student) (2019); Robert B. Goldberg, New York, New York (2021); Cynthia A. Jumper, Lubbock, Texas (2020); Liana Puscas, Durham, North Carolina (2021); Niranjan V. Rao, New Brunswick, New Jersey (2022); Luke V. Selby, Denver, Colorado (Resident) (2020) ; Krystal L. Tomei, Cleveland, Ohio (2021); Patricia L. Turner, Chicago, Illinois (2019); John P. Williams, Pittsburgh, Pennsylvania (2019).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
James G. Hinsdale, San Jose, California, Chair (2019); W. Alan Harmon, Jacksonville, Florida, Chair-Elect (2020); Betty Chu, Bloomfield Hills, Michigan (2022); Meena Davuluri, New York, New York (Resident) (2020); Lisa Egbert, Dayton, Ohio (2021); Stephen Epstein, Boston, Massachusetts (2022); Lynn Jeffers, Camarillo, California (2020); Asa Lockhart, Tyler, Texas (2022); Thomas Madejski, Medina, New York (2019); Sheila Rege, Pasco, Washington (2022); Sarah Smith, Anaheim, California (Student) (2019); Lynda M. Young, Worcester, Massachusetts (2021).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Robyn F. Chatman, Cincinnati, Ohio, Chair (2019); Michael M. Miller, Madison, Wisconsin, Chair-Elect (2022); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2019); Alexander Ding, Belmont, California (2020); Rachel Ekaireb, San Francisco, California (Student) (2019); Kira A. Geraci-Ciardullo, Mamaroneck, New York (2022); Mary LaPlante, Cleveland, Ohio (2021); Michael Lubrano, San Francisco, California (Resident) (2020); Padmini Ranasinghe, Baltimore, Maryland (2022); Bruce M. Smoller, Chevy Chase, Maryland (2019); David J. Welsh, Batesville, Indiana (2020).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Lyle S. Thorstenson, Nacogdoches, Texas, Chair; Stephen A. Imbeau, Florence, South Carolina, Secretary; Grayson W. Armstrong, Boston, Massachusetts (Resident); Brooke M. Buckley, Annapolis, Maryland; Paul J. Carniol, Summit, New Jersey; Linda B. Ford, Bellevue, Nebraska; Benjamin Z. Galper, McLean, Virginia; Dev A. GnanaDev, Colton, California; James L. Milam, Libertyville, Illinois; Elizabeth Peterson, Spokane, Washington; Miriam Rienstra Bareman, Grand Rapids, Michigan (Student); Michael Suk, Danville, Pennsylvania.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Lonnie R. Bristow	1995-1996	Daniel H. Johnson, Jr.	1996-1997	Thomas R. Reardon	1999-2000
Peter W. Carmel	2011-2012	Jeremy A. Lazarus	2012-2013	J. James Rohack	2009-2010
Yank D. Coble, Jr.	2002-2003	Robert E. McAfee	1994-1995	Randolph D. Smoak, Jr.	2000-2001
Richard F. Corlin	2001-2002	Alan R. Nelson	1989-1990	Steven J. Stack	2015-2016
Nancy W. Dickey	1998-1999	John C. Nelson	2004-2005	Robert M. Wah	2014-2015
Andrew W. Gurman	2016-2017	Nancy H. Nielsen	2008-2009	Cecil B. Wilson	2010-2011
J. Edward Hill	2005-2006	Donald J. Palmisano	2003-2004	Percy Wootton	1997-1998
Ardis D. Hoven	2013-2014	William G. Plested, III	2006-2007		

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Audrey J. Ludwig	1990-1991
Susan Hershberg Adelman	1998-2002	Justin B. Mahida	2009-2010
Kendall S. Allred	2008-2009	Omar Z. Maniya	2016-2017
Raj S. Ambay	2009-2011	Robert E. McAfee	1984-1993
Joseph P. Annis	2006-2014	Mary Anne McCaffree	2008-2016
John H. Armstrong	2002-2006	Joe T. McDonald	2005-2006
Maya A. Babu	2013-2017	Samuel J. Mackenzie	2014-2015
Timothy E. Baldwin	1987-1989	Robert R. McMillan	2002-2008
Regina M. Benjamin	1995-1998	Sandeep “Sunny” Mistry	2000-2001
Scott L. Bernstein	1991-1992	Alan R. Nelson	1980-1988
Stefano M. Bertozzi	1986-1988	John C. Nelson	1994-2003
David J. Brailer	1985-1986	Nancy H. Nielsen	2005-2007
Lonnie R. Bristow	1985-1994	Donald J. Palmisano	1996-2002
Duane M. Cady	1999-2007	Rebecca J. Patchin	1988-1989
Peter Carmel	2002-2010	Rebecca J. Patchin	2003-2011
Alice A. Chenault	1984-1985	Stephen R. Permut	2010-2018
Yank D. Coble	1994-2001	Pamela Petersen-Crair	1996-1998
David S. Cockrum	1993-1994	Dina Marie Pitta	2015-2016
MaryAnn Contogiannis	1989-1993	William G. Plested, III	1998-2005
Malini Daniel	2012-2013	Stephen Pool	1995-1996
Christopher M. DeRienzo	2006-2008	Liana Puscas	1999-2001
Nancy W. Dickey	1989-1997	Thomas R. Reardon	1990-1998
Alexander Ding	2011-2013	Kevin C. Reilly	2003-2005
William A. Dolan	2007-2011	Ryan J. Ribeira	2013-2014
Timothy T. Flaherty	1994-2003	Joseph A. Riggs	1999-2003
Melissa J. Garretson	1992-1993	J. James Rohack	2001-2008
Michael S. Goldrich	1993-1997	David A. Rosman	2002-2004
Julie K. Goonewardene	2012-2016	Samantha L. Rosman	2005-2009
Andrew W. Gurman	2007-2015	Raymond Scalettar	1985-1994
Alan C. Hartford	1989-1990	Bruce A. Scott	1998-2002
William A. Hazel, Jr.	2004-2009	Carl A. Sirio	2010-2018
Cyril M. Hetsko	2003-2011	Randolph D. Smoak, Jr.	1992-1999
Joseph M. Heyman	2002-2010	Steven J. Stack	2006-2014
J. Edward Hill	1996-2004	Lowell H. Steen	1975-1982
Ardis D. Hoven	2005-2012	Michael Suk	1994-1995
William E. Jacott	1989-1998	Andrew M. Thomas	1997-1999
Hillary D. Johnson	2001-2002	Jeffrey A. Towson	1998-1999
Matthew D. Kagan	1999-2000	Jordan M. VanLare	2011-2012
Christopher K. Kay	2008-2012	Robert M. Wah	2005-2013
Edward L. Langston	2003-2011	Peter Y. Watson	2001-2003
Matthew C. Lawyer	2004-2005	Monica C. Wehby	2011-2013
Jeremy A. Lazarus	2005-2011	Meredith C. Williams	2010-2011
D. Ted Lewers	1993-2002	Cecil B. Wilson	2002-2009
W. J. Lewis	1979-1984	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates, but are representatives of the following societies which are represented in the SSS.)

American Academy of Emergency Medicine ..... Joseph Wood, MD, JD
American Academy of Sleep Medicine ..... Patrick Strollo, MD
American Association of Endocrine Surgeons ..... Steven De Jong, MD
American Association of Hip and Knee Surgeons ..... Edward Tanner, MD
American College of Correctional Physicians ..... Charles Lee, MD
American College of Medical Toxicology ..... Charles McKay, MD
American Contact Dermatitis Society ..... Bruce Brod, MD
American Epilepsy Society ..... David M. Labiner, MD
American Society of Cytopathology ..... Swati Mehrotra, MD
American Society of Nuclear Cardiology ..... Saurabh Malhotra, MD
American Society of Regional Anesthesia and Pain Medicine ..... David Provenzano, MD
Americas Hernia Society ..... J. Scott Roth, MD
Association of Academic Physiatrists ..... Samuel Chu, MD
Association of Professors of Dermatology ..... Christopher R. Shea, MD
Korean American Medical Association ..... John Yun, MD
Society of Cardiovascular Computed Tomography ..... Dustin Thomas, MD
Society of Gynecologic Oncologists ..... Carol Brown, MD

MEMBERS OF THE HOUSE OF DELEGATES - JUNE 2019
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama

Delegate(s)
Jorge Alsip, Daphne AL
Steven P. Furr, Jackson AL
B Jerry Harrison, Haleyville AL
George C. Smith, Jr, Lineville AL

Alternate Delegate(s)
Raymond Broughton, Theodore AL
Harry Kuberg, Russelville AL
John Meigs, Jr, Brent AL
William Schneider, Huntsville AL

Resident and Fellow Sectional Alternate Delegate(s)
Amber Clark, Trussville AL

Regional Medical Student Delegate(s)
Hannah M Ficarino, Mobile AL

Alaska State Medical Association

Delegate(s)
Alex Malter, Juneau AK

Alternate Delegate(s)
Mary Ann Foland, Anchorage AK

Arizona Medical Association

Delegate(s)
Daniel P. Aspery, Phoenix AZ
Veronica K. Dowling, Show Low AZ
Gary R. Figge, Tucson AZ
Thomas H. Hicks, Tucson AZ
M Zuhdi Jasser, Phoenix AZ

Alternate Delegate(s)
Timothy Fagan, Tucson AZ
Ross F. Goldberg, Phoenix AZ
Michael Hamant, Tucson AZ
Marc Leib, Phoenix AZ
Elise Molnar, Phoenix AZ

Regional Medical Student Delegate(s)
Adam Roussas, Tucson AZ

Regional Medical Student Alternate Delegate(s)
Maddy Banerjee, Tucson AZ

Arizona Medical Association

Regional Medical Student Alternate Delegate(s)
Akshara Malla, Phoenix AZ

Arkansas Medical Society

Delegate(s)
Omar Atiq, Little Rock AR
Eugene Shelby, Hot Springs AR
Alan Wilson, Crossett AR

Alternate Delegate(s)
Amy Cahill, Pine Bluff AR
Stephen Magie, Conway AR

California Medical Association

Delegate(s)
David H. Aizuss, Encino CA
Barbara J. Arnold, Sacramento CA
Patricia L. Austin, Alamo CA
Edward Bentley, Santa Barbara CA
Peter N. Bretan, Jr, Novato CA
J Brennan Cassidy, Newport Beach CA
Luther Cobb, Eureka CA
Alexander Ding, Belmont CA
Gordon Fung, San Francisco CA
Dev A. GnanaDev, Redlands CA
James T. Hay, Del Mar CA
Robert Hertzka, Rancho Santa Fe CA
James G. Hinsdale, San Jose CA
Samuel Huang, Los Angeles CA
Vito Imbasciani, Los Angeles CA
Joshua Lesko, San Diego CA
Arthur N. Lurvey, Los Angeles CA
Ramin Manshadi, Stockton CA
Theodore Mazer, San Diego CA
Albert Ray, San Diego CA
Neil Rens, Menlo Park CA
Tatiana W. Spirtos, Redwood City CA
James J. Strebig, Irvine CA

Alternate Delegate(s)
Dirk Stephen Baumann, Burlingame CA
Jeffrey Brackett, Ventura CA

This list does not reflect temporary changes for this meeting.

California Medical Association

Alternate Delegate(s)

Lawrence Cheung, San Francisco CA
James Cotter, Fairfield CA
Melanie Crane, Riverside CA
Suparna Dutta, Oakland CA
George Fouras, Los Angeles CA
Alexandra Iacob, Loma Linda CA
Dayna Isaacs, El Dorado Hills CA
Scott Richard Karlan, West Hollywood CA
Nikan Khatibi, Laguna Niguel CA
Mark H. Kogan, San Pablo CA
Sandra Mendez, Sacramento CA
Chang Na, Bakersfield CA
Richard Pan, Sacramento CA
Mihir Parikh, La Jolla CA
Sion Roy, Torrance CA
Joseph E. Scherger, San Diego CA
Holly Yang, San Diego CA
Paul Yost, Seal Beach CA

Resident and Fellow Sectional Delegate(s)

Jacob Burns, Sacramento CA
Hunter Pattison, Sacramento CA

Resident and Fellow Sectional Alternate Delegate(s)

Sophia Yang, San Jose CA

Regional Medical Student Delegate(s)

Drayton Harvey, Los Angeles CA

Colorado Medical Society

Delegate(s)

David Downs, Denver CO
Jan Kief, Highlands Ranch CO
A. "Lee" Morgan, Denver CO
Tamaan Osbourne-Roberts, Denver CO
Lynn Parry, Littleton CO

Alternate Delegate(s)

Carolynn Francavilla, Lakewood CO
Rachelle M. Klammer, Denver CO
Katie Lozano, Centennial CO
Brigitta J. Robinson, Centennial CO
Michael Volz, Englewood CO

Regional Medical Student Delegate(s)

Adam Panzer, Staten Island NY

Colorado Medical Society

Regional Medical Student Alternate Delegate(s)

Iris Burgard, Denver CO
Halea K Meese, Denver CO

Connecticut State Medical Society

Delegate(s)

Michael L. Carius, Stratford CT
Michael M. Deren, New London CT
Alfred Herzog, Hartford CT
Theodore Zanker, Cheshire CT

Alternate Delegate(s)

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Niva Lubin-Johnson, Chicago IL
Vikram B. Patel, South Barrington IL

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Neha Siddiqui, Urbana IL
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Farhad Ghamsari, Chicago IL

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Regional Medical Student Alternate Delegate(s)

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David Swee, Piscataway NJ

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Regional Medical Student Alternate Delegate(s)

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Bahadar Srichawla, W Hempstead NY
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Rachel Thomas, Philadelphia PA

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Hans T. Zuckerman, Lebanon PA

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Gonzalo V. Gonzalez-Liboy, Carolina PR

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Regional Medical Student Alternate Delegate(s)
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Nita Shumaker, Hixson TN
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Christopher E. Young, Signal Mtn TN

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Rocklin Shumaker, Johnson City TN

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Gary Floyd, Keller TX
John T. Gill, Dallas TX

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Leslie H. Secrest, Dallas TX
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E. Linda Villarreal, Edinburg TX
Arlo F. Weltge, Bellaire TX

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John G. Flores, Little Elm TX
Gregory M. Fuller, Keller TX
Laura Faye Gephart, McAllen TX
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Cynthia Jumper, Lubbock TX
Faith Mason, Galveston TX
M. Theresa Phan, Austin TX
Jennifer Rushton, Austin TX
Elizabeth Torres, Sugar Land TX
Roxanne Tyroch, El Pasco TX
Sherif Z. Zaafran, Houston TX

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Jonathan Eledge, Galveston TX

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Utah Medical Association

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Jon Taylor-Fishwick, Suffolk VA

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Matthew Grierson, Bothell WA
Nariman Heshmati, Mukliteo WA
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Alternate Delegate(s)

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Tosha Wetterneck, Madison WI

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Barbara Hummel, Greenfield WI
Don Lee, Franklin WI
Keshni Ramnanan, Summit WI

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Anna Heffron, Madison WI

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Delegate(s)

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Wyoming Medical Society

Alternate Delegate(s)

Paul Johnson, Cheyenne WY

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Alternate Delegate(s)

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Air Force

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Stephen Richards, Spirit Lakes IA

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Janet West, Pensacola FL

J. Mack Worthington, Chattanooga TN

Alternate Delegate(s)

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Julie K. Wood, Leawood KS

American Academy of Hospice and Palliative Medicine

Delegate(s)

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American Academy of Hospice and Palliative Medicine

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Eugene Scharf, Rochester MN

Resident and Fellow Sectional Alternate Delegate(s)
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American Academy of Pediatrics

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Carlo Milani, New York NY
Julie Ellen Witkowski, Rochester MN

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Delegate(s)
Barry Wall, Providence RI

Alternate Delegate(s)
Jennifer Piel, Seattle WA

This list does not reflect temporary changes for this meeting.

American Association for Geriatric Psychiatry

Delegate(s)

Allan Anderson, Easton MD

Sandra Swantek, Chicago IL

American Association for Hand Surgery

Delegate(s)

Peter C. Amadio, Rochester MN

Alternate Delegate(s)

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American Association for Thoracic Surgery

Delegate(s)

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Alternate Delegate(s)

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American Association of Clinical Endocrinologists

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American Association of Clinical Urologists

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Alternate Delegate(s)

Martin Dineen, Dayton Beach FL

American Association of Gynecologic Laparoscopists

Delegate(s)

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American Association of Neurological Surgeons

Delegate(s)

Kenneth S. Blumenfeld, San Jose CA

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Alternate Delegate(s)

Krystal L. Tomei, Lyndhurst OH

Resident and Fellow Sectional Delegate(s)

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American Association of Neuromuscular & Electrodiagnostic Medicine

Delegate(s)

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Alternate Delegate(s)

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American Association of Physicians of Indian Origin

Alternate Delegate(s)

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American Association of Plastic Surgeons

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American Association of Public Health Physicians

Delegate(s)

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Alternate Delegate(s)

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American College of Cardiology

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M Eugene Sherman, Englewood CO

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L. Samuel Wann, Whitefish Bay WI

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This list does not reflect temporary changes for this meeting.

American College of Chest Physicians (CHEST)

Delegate(s)

Neeraj Desai, Schaumburg IL
D Robert McCaffree, Oklahoma City OK

American College of Emergency Physicians

Delegate(s)

Michael D. Bishop, Bloomington IN
Brooks F. Bock, Vail CO
Erick Eiting, New York NY
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Hilary E. Fairbrother, Houston TX
John C. Moorhead, Portland OR
Ashley Norse, Jacksonville FL

Alternate Delegate(s)

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Vidor Friedman, Windermere FL
Zachary Jarou, Chicago IL
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Reid Orth, Alexandria VA

Resident and Fellow Sectional Delegate(s)

Scott Pasichow, Warwick RI

Resident and Fellow Sectional Alternate Delegate(s)

Karina Sanchez, Johnstown PA

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Delegate(s)

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American College of Medical Genetics & Genomics

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Alternate Delegate(s)

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Delegate(s)

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Delegate(s)

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Alternate Delegate(s)

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Delegate(s)

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American College of Physicians

Delegate(s)

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Arl Van. Moore, Charlotte NC
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Geraldine Mc Ginty, New York NY

This list does not reflect temporary changes for this meeting.

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Resident and Fellow Sectional Delegate(s)

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Delegate(s)

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Delegate(s)

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This list does not reflect temporary changes for this meeting.

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Crystal C. Wright, Houston TX
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Resident and Fellow Sectional Alternate Delegate(s)
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This list does not reflect temporary changes for this meeting.

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Delegate(s)

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Army

Delegate(s)

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This list does not reflect temporary changes for this meeting.

Army

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Delegate(s)

Stephen Chan, Closter NJ

College of American Pathologists

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William V. Harrer, Haddonfield NJ
Mark S. Synovec, Topeka KS

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Joseph Sanfrancesco, Charleston SC
Susan Strate, Wichita Falls TX

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Resident and Fellow Sectional Alternate Delegate(s)

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Alternate Delegate(s)

Maya A. Babu, Boston MA

Contact Lens Association of Ophthalmologists

Delegate(s)

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Alternate Delegate(s)

S Lance Forstot, Littleton CO

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Palak U. Choksi, Ann Arbor MI

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GLMA

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Alternate Delegate(s)

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Alternate Delegate(s)

Jim Cheung, New York NY

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Delegate(s)

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Alternate Delegate(s)

Nancy Crum, Poway CA

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Alternate Delegate(s)

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International College of Surgeons-US Section

Delegate(s)

Raymond A. Dieter, Jr, Glen Ellyn IL

Alternate Delegate(s)

Wickii Vigneswaran, Maywood IL

International Society for the Advancement of Spine Surgery

Delegate(s)

Gunnar B. Andersson, Chicago IL

Alternate Delegate(s)

Morgan P. Lorio, Nashville TN

International Society of Hair Restoration Surgery

Delegate(s)

Carlos J. Puig, Houston TX

This list does not reflect temporary changes for this meeting.

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Delegate(s)
Michelle Jorden, San Jose CA
Alternate Delegate(s)
J Scott. Denton, Bloomington IL

National Medical Association

Delegate(s)
Sandra L. Gadson, Merrillville IN
Alternate Delegate(s)
Gary Dennis, Frisco TX

Navy

Delegate(s)
Paul D. Pearigen, San Dieg CA
Alternate Delegate(s)
Christopher Quarles, FPO AE

North American Neuromodulation Society

Delegate(s)
Haroon I. Hameed, Arlington VA

North American Neuro-Ophthalmology Society

Delegate(s)
Thomas R. Mizen, Chicago IL
Alternate Delegate(s)
Nicholas Volpe, Chicago IL

North American Spine Society

Delegate(s)
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William Mitchell, Mount Laurel NJ

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Delegate(s)
Ethan Lazarus, Greenwood Village CO
Alternate Delegate(s)
Fatima Cody Stanford, Boston MA

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Delegate(s)
Michael C. Brunner, Madison WI
Kevin C. Reilly, Elizabethtown KY
Laura E. Traube, Templeton CA
Alternate Delegate(s)
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Delegate(s)
Louis H. Diamond, Rockville MD
Alternate Delegate(s)
Rebecca Schmidt, Morgantown WV

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Delegate(s)
J. Jeffrey Marshall, Atlanta GA
Alternate Delegate(s)
Clifford Kavinsky, Chicago IL

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Delegate(s)
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Alternate Delegate(s)
Erica Dommasch, Boston MA

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Delegate(s)
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Society of American Gastrointestinal Endoscopic Surgeons

Delegate(s)
Kevin Reavis, Portland OR
Paresh Shah, New York NY
Alternate Delegate(s)
Eli Lerner, Jacksonville FL

Society of Critical Care Medicine

Delegate(s)
Russell C. Raphaely, Wilmington DE
Tina R. Shah, Atlanta GA
Alternate Delegate(s)
Diane T Gowski, Clearwater FL

Society of Hospital Medicine

Delegate(s)
Steven Deitelzweig, New Orleans LA
Brad Flansbaum, Danville PA

Society of Interventional Radiology

Delegate(s)
Meridith Englander, Albany NY

This list does not reflect temporary changes for this meeting.

Society of Interventional Radiology

Alternate Delegate(s)

Terence Matalon, Philadelphia PA

Society of Laparoendoscopic Surgeons

Delegate(s)

Camran Nezhat, Palo Alto CA

Society of Nuclear Medicine and Molecular Imaging

Delegate(s)

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Alternate Delegate(s)

Hazem H. Chehabi, Newport Beach CA

Society of Thoracic Surgeons

Delegate(s)

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Spine Intervention Society

Delegate(s)

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Kate Sully, Portage MI

Triological Society, The

Delegate(s)

Michael E. Hoffer, Miami FL

Undersea and Hyperbaric Medical Society

Delegate(s)

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US and Canadian Academy of Pathology

Delegate(s)

Nicole Riddle, Tampa FL

Daniel Zedek, Chapel Hill NC

Alternate Delegate(s)

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Nirali M. Patel, Durham NC

US Public Health Service

Delegate(s)

Brian M Lewis, Silver Spring MD

US Public Health Service

Alternate Delegate(s)

Dana Thomas, Yardley PA

Veterans Affairs

Delegate(s)

Carolyn M. Clancy, Washington DC

This list does not reflect temporary changes for this meeting.

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Alternate Delegate(s)
Alma B. Littles, Tallahassee FL

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Alternate Delegate(s)
Devdutta Sangvai, Durham NC

International Medical Graduates Section

Delegate(s)
Ronit Katz, Cupertino CA
Alternate Delegate(s)
Ricardo Correa, Phoenix AZ

Medical Student Section

Delegate(s)
Joy Lee, Washington DC
Alternate Delegate(s)
Daniel Pfeifle, Sioux Falls SD

Minority Affairs Section

Delegate(s)
Dionne Hart, Rochester MN
Alternate Delegate(s)
Tyeese Gaines, Bloomfield NJ

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Delegate(s)
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Alternate Delegate(s)
Raj B. Lal, Oakbrook IL

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Alternate Delegate(s)
Amar Kelkar, Peoria IL

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Delegate(s)
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Alternate Delegate(s)
Luis T Sanchez, Newtonville MA

Women Physicians Section

Delegate(s)
Josephine Nguyen, Vernon Hills IL
Alternate Delegate(s)
Lauren Engel, Milwaukee WI

Young Physicians Section

Delegate(s)
Kavita Arora, Cleveland Hts OH
Alternate Delegate(s)
Alisha Reiss, Gettysburg OH

This list does not reflect temporary changes for this meeting.

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2019 Annual Meeting
Notes on Orders of Business
Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Saturday, June 8, 2:00 – 6:00 pm

SECOND SESSION, Sunday, June 9, 8:00 – 8:30 am

THIRD SESSION, Monday, June 10, 2:00 – 6:00 pm

FOURTH SESSION, Tuesday, June 11, 9:00 am – 3 pm

> *Note: The Inauguration of Patrice A. Harris, MD, as the 174th President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.*

FIFTH SESSION, Wednesday, June 12, 9:00 am – noon

SUMMARY OF FISCAL NOTES (A-19)

BOT Report(s)

01 Annual Report: Info Report
02 New Specialty Organizations Representation in the House of Delegates: Minimal
03 2018 Grants and Donations: Info Report
04 AMA 2020 Dues: no significant fiscal impact
05 Update on Corporate Relationships: Info Report
06 Redefining AMA's Position on ACA and Healthcare Reform: Info Report
07 AMA Performance, Activities and Status in 2018: Info Report
08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019: Info Report
09 Council on Legislation Sunset Review of 2009 House Policies: n/a
10 Conduct at AMA Meetings and Events: Estimated cost between $75,000 - $100,000 for Conduct Liaison fees and travel expenses, as well as potential meeting costs for the Committee on Conduct at AMA Meetings and Events
11 Policy and Economic Support for Early Child Care: Minimal
12 Data Used to Apportion Delegates:
13 Employed Physician Bill of Rights and Basic Practice Professional Standards: Minimal
14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing: Negotiated Payment Schedules: Minimal
15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization: Minimal
16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients: Modest
17 Ban on Medicare Advantage "No Cause" Network Terminations: Modest
18 Increased Use of Body-Worn Cameras by Law Enforcement Officers: Modest
19 FDA Conflict of Interest: Minimal
20 Safe and Efficient E-Prescribing: Minimal
21 Augmented Intelligence in Health Care: Modest
22 Inappropriate Use of CDC Guidelines for Prescribing Opioids: Minimal
23 Prior Authorization Requirements for Post-Operative Opioids: Minimal
24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion: 0
25 All Payer Graduate Medical Education Funding: Minimal
26 Research Handling of De-Identified Patient Information: Minimal
27 Advancing Gender Equity in Medicine: Modest
28 Opposition to Measures that Criminalize Homelessness: Minimal
29 Improving Safety and Health Code Compliance in School Facilities: Minimal
30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs: Minimal
31 Non-Payment and Audit Takebacks by CMS: Minimal
32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff: n/a

CC&B Report(s)

01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing: n/a
02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws: Info. Report

CEJA Opinion(s)

01 Amendment to E-2.2.1, "Pediatric Decision Making": Info. Report

SUMMARY OF FISCAL NOTES (A-19)

CEJA Report(s)

01 Competence, Self-Assessment and Self-Awareness: Minimal
02 Physician Assisted Suicide: n/a
03 CEJA's Sunset Review of 2009 House Policies: Minimal
04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Info. Report
05 Discrimination Against Physicians by Patients: Info. Report

CLRPD Report(s)

01 Demographic Characteristics of the House of Delegates and AMA Leadership: Info. Report

CME Report(s)

01 Council on Medical Education Sunset Review of 2009 House Policies: Minimal
02 Update on Maintenance of Certification and Osteopathic Continuous Certification: Modest
03 Standardizing the Residency Match System and Timeline: Minimal
04 Augmented Intelligence in Medical Education:
05 Accelerating Change in Medical Education Consortium Outcomes: Info. Report
06 Study of Medical Student, Resident, and Physician Suicide: $81,500
07 For-Profit Medical Schools or Colleges: Info. Report

CMS Report(s)

01 Council on Medical Service Sunset Review of 2009 AMA House Policies: Minimal
02 Covering the Uninsured Under the AMA Proposal for Reform: Minimal
03 Medicare Coverage for Dental Services: Minimal
04 Reclassification of Complex Rehabilitation Technology: Minimal
05 The Impact of Pharmacy Benefit Managers on Patients and Physicians: Minimal
06 Preventive Prostate Cancer Screening: Minimal
07 Hospital Consolidation: Minimal
08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor: Minimal
09 Health Plan Payment of Patient Cost-Sharing: Minimal
10 Alternative Payment Models and Vulnerable Populations: Minimal
11 Corporate Investors: Minimal

CSAPH Report(s)

01 CSAPH Sunset Review of 2009 House of Delegates Policies: Minimal
02 Drug Shortages: 2019 Update: Info. Report
03 Low Nicotine Product Standard: Minimal
04 Vector-Borne Diseases: Minimal

HOD Comm on Compensation of the Officers

01# Report of the House of Delegates Committee on Compensation of the Officers: Maximum annual stipend is $87K.

SUMMARY OF FISCAL NOTES (A-19)

Joint Report(s)

01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure: Minimal

Report of the Speakers

01 Recommendations for Policy Reconciliation: Minimal

Resolution(s)

001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations: minimal
002 Addressing Existential Suffering in End-of-Life Care: Moderate
003 Conforming Sex and Gender Designation on Government IDs and Other Documents: Minimal
004 Reimbursement for Care of Practice Partner Relatives: Modest
005 Right for Gamete Preservation Therapies: Moderate
006 Use of Person-Centered Language: Minimal
007 Delegation of Informed Consent: Modest
008# Preventing Anti-Transgender Violence: Modest
009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: not yet determined
010# Covenants not to Compete: Minimal
011# Mature Minor Consent to Vaccinations: Minimal
012# Improving Body Donation Regulation: Minimal
013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court: Modest
014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations: Minimal
015# Opposing Mandated Reporting of People Who Question Their Gender Identity: Minimal
016# Sexual and Gender Minority Populations in Medical Research: Minimal
017# National Guidelines for Guardianship: Modest
018# Support for Requiring Investigations into Deaths of Children in Foster Care: Minimal
019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes: not yet determined
020# Changes to E-5.7, “Physician-Assisted Suicide”: not yet determined
021# Health, In All Its Dimensions, Is a Basic Right: Modest
022# Opposition to Involuntary Civil Commitment for Substance Use Disorder: Modest
101 Health Hazards of High Deductible Insurance: minimal
102 Use of HSAs for Direct Primary Care: Modest
103 Health System Improvement Standards: Modest
104 Adverse Impacts of Single Specialty Independent Practice Associations: Minimal
105 Payment for Brand Medications When the Generic Medication is Recalled: Modest
106 Raising Medicare Rates for Physicians: Modest
107 Investigate Medicare Part D - Insurance Company Upcharge: Minimal
108 Congressional Healthcare Proposals: Modest
109 Part A Medicare Payment to Physicians: Modest
110 Establishing Fair Medicare Payer Rates: Modest
111 Practice Overhead Expense and the Site-of-Service Differential: Modest
112 Health Care Fee Transparency: Modest

SUMMARY OF FISCAL NOTES (A-19)

Resolution(s)

113 Ensuring Access to Statewide Commercial Health Plans: Modest
114 Ensuring Access to Nationwide Commercial Health Plans: Modest
115 Safety of Drugs Approved by Other Countries: Modest
116 Medicare for All: Modest
117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use: Modest
118 Pharmaceutical Pricing Transparency: Modest
119# Returning Liquid Oxygen to Fee Schedule Payment: Modest
120# Medicare Coverage of Hearing Aids: Modest
121# Maintenance Hemodialysis for Undocumented Persons: Modest
122# Reimbursement for Telemedicine Visits: Modest
123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder: Minimal
124# Increased Affordability and Access to Hearing Aids and Related Care: Modest
125# Mitigating the Negative Effects of High-Deductible Health Plans: Modest
126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies: Modest
127# Eliminating the CMS Observation Status: Modest
201 Assuring Patient Access to Kidney Transplantation: Modest
202 Reducing the Hassle Factor in Quality Improvement Programs: Modest
203 Medicare Part B and Part D Drug Price Negotiation: Modest
204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs: Modest
205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary: Minimal
206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade: Modest
207 Direct-to-Consumer Genetic Tests: Modest
208 Repeal or Modification of the Sunshine Act: Minimal
209 Mandates by ACOs Regarding Specific EMR Use: Modest
210 Air Ambulances: Minimal
211 Use of FAIR Health: Modest
212 Pharmacy Benefit Managers: Modest
213 Financial Penalties and Clinical Decision-Making: Minimal
214 The Term Physician: Modest
215 Reimbursement for Health Information Technology: Modest
216 Eliminate the Word Provider from Healthcare Contracts: Minimal
217 Medicare Vaccine Billing: Modest
218 Payment for Medications Used Off Label for Treatment of Pain: Modest
219 Medical Marijuana License Safety: Modest
220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders: Modest
221 Extending Medicaid Coverage to 12-Months Postpartum: Modest
222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads: Modest
223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record: Minimal
224 Extending Pregnancy Medicaid to One Year Postpartum: Modest
225 DACA in GME: Minimal

SUMMARY OF FISCAL NOTES (A-19)

Resolution(s)

226 Physician Access to Their Medical and Billing Records: Modest
227 Controlled Substance Management: Modest
228 Truth in Advertising: Modest
229 Clarification of CDC Opioid Prescribing Guidelines: Modest
230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes: Modest
231# Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability Act: Minimal
232# COPD National Action Plan: Modest
233# GME Cap Flexibility: Modest
234# Improved Access to Non-Opioid Therapies: Modest
235# Prescription Coverage of the Lidocaine Transdermal Patch: Modest
236# Support for Universal Basic Income Pilot Studies: Minimal
237# Opportunities in Blockchain for Healthcare: Modest
238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis: Modest
239# Improving Access to Medical Care Through Tax Treatment of Physicians: Modest
240# Formation of Collective Bargaining Workgroup: Modest
241# Facilitation of Research with Medicare Claims Data: Modest
301 American Board of Medical Specialties Advertising: minimal
302 The Climate Change Lecture for US Medical Schools: Estimated cost of $50,000 includes one FTE, management review, and in house designer
303 Graduate Medical Education and the Corporate Practice of Medicine: Minimal
304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs: Modest
305 Lack of Support for Maintenance of Certification: Minimal
306 Interest Rates and Medical Education: Minimal
307 Mental Health Services for Medical Students: Minimal
308 MOC Moratorium: Minimal
309 Promoting Addiction Medicine During a Time of Crisis: Minimal
310 Mental Health Care for Medical Students: Minimal
311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure: Modest
312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians: Modest
313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows: Modest
314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes: Minimal
315 Scholarly Activity by Resident and Fellow Physicians: Modest
316 Medical Student Debt: Modest
317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities: Modest
318 Rural Health Physician Workforce Disparities: Modest
319# Adding Pipeline Program Participation Questions to Medical School Applications: Modest
320# Opioid Education in Medical Schools: Modest
321# Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession: Modest
322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools: Minimal

SUMMARY OF FISCAL NOTES (A-19)

Resolution(s)

401 Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies: Minimal
402 Bullying in the Practice of Medicine: Minimal
403 White House Initiative on Asian Americans and Pacific Islanders: Modest
404 Shade Structures in Public and Private Planning and Zoning Matters: Minimal
405 Gun Violence Prevention: Safety Features: Minimal
406 Reduction in Consumption of Processed Meats: Minimal
407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents: Modest
408 Banning Edible Cannabis Products: Modest
409 Addressing the Vaping Crisis: Minimal
410 Reducing Health Disparities Through Education: Modest
411 AMA to Analyze Benefits / Harms of Legalization of Marijuana: Modest
412 Regulating Liquid Nicotine and E-Cigarettes: Modest
413 End the Epidemic of HIV Nationally: Minimal
414 Patient Medical Marijuana Use in Hospitals: Modest
415 Distracted Driving Legislation: Modest
416 Non-Medical Exemptions from Immunizations: Modest
417 Improved Health in the United States Prison System Through Hygiene and Health Educational Programming for Inmates and Prison Staff: Modest
418 Eliminating the Death Toll from Combustible Cigarettes: Modest
419 Universal Access for Essential Public Health Services: Modest
420 Coordinating Correctional and Community Healthcare: Minimal
421 Contraception for Incarcerated Women: Minimal
422 Promoting Nutrition Education Among Healthcare Providers: Minimal
423# Mandatory Immunizations for Asylum Seekers: Modest
424# Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury: Modest
425# Distracted Driver Education and Advocacy: Estimated cost of $65K includes formlation of campaign, development of module and implementation of web based campaign,
426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities: Modest
427# Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled: Modest
428# Dangers of Vaping: Minimal
429# Support for Children of Incarcerated Parents: Minimal
430# Compassionate Release for Incarcerated Patients: Modest
431# Eliminating Recommendations to Restrict Dietary Cholesterol and Fat: Minimal
432# Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals: Minimal
433# Transformation of Rural Community Public Health Systems: Modest
434# Change in Marijuana Classification to Allow Research: Modest
501 USP 800: minimal
502 Destigmatizing the Language of Addiction: Modest
503 Addressing Healthcare Needs of Children of Incarcerated Parents: Minimal
504 Screening, Intervention, and Treatment for Adverse Childhood Experiences: Minimal
505 Glyphosate Studies: Minimal

SUMMARY OF FISCAL NOTES (A-19)

Resolution(s)

506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements: Minimal

507 Removing Ethylene Oxide as a Medical Sterilant from Healthcare: Minimal

508 Benzodiazepine and Opioid Warning: Minimal

509 Addressing Depression to Prevent Suicide Epidemic: Minimal

510 The Intracranial Hemorrhage Anticoagulation Reversal Initiative: Minimal

511 Mandating Critical Congenital Heart Defect Screening in Newborns: Minimal

512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients: Minimal

513 Determining Why Infertility Rates Differ Between Military and Civilian Women: Minimal

514 Opioid Addiction: Modest

515 Reversing Opioid Epidemic: Modest

516 Alcohol Consumption and Health: Minimal

517# Compounding: Modest

518# Chemical Variability in Pharmaceutical Products: Modest

519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment: Minimal

520# Substance Use During Pregnancy: Minimal

521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter: Modest

522# Improved Deferral Periods for Blood Donors: Minimal

523# Availability and Use of Low Starting Opioid Doses: Minimal

524# Availability of Naloxone Boxes: Minimal

525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents: Minimal

526# Trauma-Informed Care Resources and Settings: Minimal

527# Increasing the Availability of Bleeding Control Supplies: Minimal

528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: Minimal

529# Adverse Impacts of Delaying the Implementation of Public Health Regulations: Modest

530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program: Minimal

601 AMA Policy Statement with Editorials: indeterminate - the cost of implementing this resolution is varied given the large volume of content across the 13 journals in the JAMA Network as well as the wealth of AMA policy. At a minimun implementation would require the addition of 3 full time staff and would result in increased operational costs associated with extra paper, printing, binding, mailing, and layout of larger print issues.

602 Expectations for Behavior at House of Delegates Meetings: Minimal

603 Creation of an AMA Election Reform Committee: Estimated cost of $15,000 to $25,000 to study.

604 Engage and Collaborate with The Joint Commission: Minimal

605 State Societies and the AMA Litigation Center: Minimal

606 Investigation into Residents, Fellows and Physician Unions: Modest

607 Re-establishment of National Guideline Clearinghouse: Modest

608 Financial Protections for Doctors in Training: Indeterminate

609 Update to AMA Policy H-525.998, "Women in Organized Medicine": Minimal

610 Mitigating Gender Bias in Medical Research: Minimal

611# Election Reform: Estimated cost to implement the resolution is between $15K-$25K to convene a task force.

612# Request to AMA for Training in Health Policy and Health Law: Est cost of $200,000 to establish curriculum, host event, start fellowship, host fellow. Fellow expeses at least 150K annually

613# Language Proficiency Data of Physicians in the AMA Masterfile: not yet determined

SUMMARY OF FISCAL NOTES (A-19)

Resolution(s)

614# Racial and Ethnic Identity Demographic Collection by the AMA: Modest

615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership: not yet determined

616# TIME'S UP Healthcare: Minimal

617# Disabled Physician Advocacy: Modest

701 Coding for Prior Authorization Obstacles: minimal

702 Peer Support Groups for Second Victims: Estimated cost of $465K to determine appropriate collaborative partners, develop survey instrument with input from organizational partners, program survey into online survey platform, print and mail post-cards with survey URL information to all living physician records in AMA Masterfile, analyze data and report findings.

703 Preservation of the Patient-Physician Relationship: Modest

704 Prior Authorization Reform: Modest

705 Physician Requirements for Comprehensive Stroke Center Designation: Minimal

706 Hospital Falls and "Never Events" - A Need for More in Depth Study: Modest

707 Cost of Unpaid Patient Deductibles on Physician Staff Time: Modest

708# Access to Psychiatric Treatment in Long Term Care: Modest

709# Promoting Accountability in Prior Authorization: Modest

710# Council for Affordable Quality Healthcare Attestation: not yet determined

711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs: Modest

712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives: not yet determined

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000

 # Contained in the Handbook Addendum

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

02 New Specialty Organizations Representation in the House of Delegates

26 Research Handling of De-Identified Patient Information

CC&B Report(s)

01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing

CEJA Report(s)

01 Competence, Self-Assessment and Self-Awareness

02 Physician Assisted Suicide

03 CEJA's Sunset Review of 2009 House Policies

Resolution(s)

001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations

002 Addressing Existential Suffering in End-of-Life Care

003 Conforming Sex and Gender Designation on Government IDs and Other Documents

004 Reimbursement for Care of Practice Partner Relatives

005 Right for Gamete Preservation Therapies

006 Use of Person-Centered Language

007 Delegation of Informed Consent

008# Preventing Anti-Transgender Violence

009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

010# Covenants not to Compete

011# Mature Minor Consent to Vaccinations

012# Improving Body Donation Regulation

013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court

014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations

015# Opposing Mandated Reporting of People Who Question Their Gender Identity

016# Sexual and Gender Minority Populations in Medical Research

017# National Guidelines for Guardianship

018# Support for Requiring Investigations into Deaths of Children in Foster Care

019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes

020# Changes to E-5.7, “Physician-Assisted Suicide”

021# Health, In All Its Dimensions, Is a Basic Right

022# Opposition to Involuntary Civil Commitment for Substance Use Disorder

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-A-19

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the applications of the American Academy of Sleep Medicine and the American Society of Cytopathology for national medical specialty organization representation in the American Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

The applications were considered using criteria developed by the Council on Long Range Planning and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

Organizations seeking admission were asked to provide appropriate membership information to the AMA. That information was analyzed to determine AMA membership, as required under criterion 3. A summary of this information is attached to this report as Exhibit B.

In addition, organizations must submit a letter of application in a designated format. This format lists the above-mentioned guidelines followed by each organization's explanation of how it meets each of the criteria.

Before a society is eligible for admission to the HOD, it must participate in the SSS for three years. Both organizations have actively participated in the SSS for more than three years.

Review of the materials and discussion during the SSS meeting at the 2018 Interim Meeting indicated that the American Academy of Sleep Medicine and the American Society of Cytopathology meet the criteria for representation in the HOD.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the American Academy of Sleep Medicine and the American Society of Cytopathology be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500 to implement.

APPENDIX

Exhibit A

GUIDELINES FOR REPRESENTATION IN & ADMISSION TO THE HOUSE OF DELEGATES:

National Medical Specialty Societies

1) The organization must not be in conflict with the constitution and bylaws of the American Medical Association by discriminating in membership on the basis of race, religion, national origin, sex, or handicap.

2) The organization must (a) represent a field of medicine that has recognized scientific validity; and (b) not have board certification as its primary focus, and (c) not require membership in the specialty organization as a requisite for board certification.

3) The organization must meet one of the following criteria:

   - 1,000 or more AMA members;
   - At least 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
   - Have been represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.

4) The organization must be established and stable; therefore, it must have been in existence for at least 5 years prior to submitting its application.

5) Physicians should comprise the majority of the voting membership of the organization.

6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office.

7) The organization must be active within its field of medicine and hold at least one meeting of its members per year.

8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.

9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.

10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

1. To cooperate with the AMA in increasing its AMA membership.

2. To keep its delegate to the House of Delegates fully informed on the policy positions of the organizations so that the delegate can properly represent the organization in the House of Delegates.

3. To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

4. To disseminate to its membership information to the actions taken by the House of Delegates at each meeting.

5. To provide information and data to the AMA when requested.

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
American Academy of Sleep Medicine	1,202 of 5,185 (23%)
American Society of Cytopathology	286 of 1,371 (21%)

REPORT 26 OF THE BOARD OF TRUSTEES (A-19)
Research Handling of De-Identified Patient Information
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, Policy D-315.975, "Research Handling of De-Identified Patient Information," was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to study the handling of de-identified patient data and report the findings and recommendations to the House of Delegates at the 2019 Annual Meeting. This report outlines appropriate and inappropriate use of de-identified patient data, perspectives from stakeholders in organized medicine, potential ethical concerns of the commercial use of such data, regulatory implications, and recommendations for the future use of de-identified patient data

Protected health information (PHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with patient health information. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Security of PHI safeguards patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment. However, the use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-19

Subject: Research Handling of De-Identified Patient Information

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

INTRODUCTION

At the 2018 Annual Meeting, Policy D-315.975, "Research Handling of De-Identified Patient Information," was adopted by the House of Delegates. This policy directs the American Medical Association (AMA) to study the handling of de-identified patient data and report the findings and recommendations to the House of Delegates at the 2019 Annual Meeting. This report outlines appropriate and inappropriate use of de-identified patient data, perspectives from stakeholders in organized medicine, potential ethical concerns of the commercial use of such data, regulatory implications, and recommendations for the future use of de-identified patient data.

BACKGROUND

Health-related information collected during the course of clinical care has always been of great interest for a number of secondary use cases, including scientific research in the academic and commercial settings, marketing for pharmaceutical and medical device companies, and a wide variety of other uses. More recently, a new and substantial interest has been raised from technology companies who seek to use patient data to build new clinical tools using machine learning and "big data." Clinical data is the topic of significant ethical guidance and regulation at both the state and federal levels, focused primarily on the appropriate use and handling of identifiable patient information. Little guidance exists, however, on the use of de-identified patient data.

A variety of entities, including provider organizations, clinical laboratories, and commercial entities such as personal genomics companies, may collect patient data intended for clinical use or to deliver genetics information, and then resell de-identified data to other entities for other purposes. For example, 23andMe, a personal genomics and biotech service, sells de-identified user data to pharmaceutical companies that use it to conduct research on various diseases. Concerns arise in that when the data is de-identified, it is no longer considered PHI and therefore patient authorization or consent for use is not required and therefore not solicited—meaning that patients are not always aware how their data is being used.[1] For example, research using de-identified data such as biologic specimens may result in scientific knowledge that has commercial value. Proper consent for use and/or disclosure of commercial interest in this research is ideal but not always documented, sometimes resulting in legal action against physicians or researchers.[2]

In addition, there is a perceived lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about

access to such information that is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior. In addition, the sale of de-identified data by clinicians and provider organizations may create a real or perceived conflict of interest, which could lead to a loss of patient confidence.

What is Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides extensive protections for patient data that is considered protected health information (PHI).[3] PHI is information, including demographic information, which relates to an individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.[4] PHI includes many common identifiers (e.g., name, address, birth date, Social Security Number) when they can be associated with the health information listed above. The HIPAA Privacy Rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.[5] Security of PHI safeguards patients from the risk of their data being released or used in manners that could result in discrimination, stigmatization, or embarrassment.[6, 7] Section 164.514(a) of the HIPAA Privacy Rule establishes standards for de-identifying PHI so individuals can no longer be identified by any portion of the data. The use, sale, or distribution of de-identified patient data is not prohibited under HIPAA, since once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer considered PHI and, thus, may be used and disclosed by a covered entity or health information organization (HIO) for any purpose.[8]

In addition to regulation at the federal level, state lawmakers have exhibited a general trend toward establishing stricter guards on the use of patient data and the requirement for patient consent, some of which reflect standards set forth in the European Union's recent General Data Protection Regulation (GDPR).[9] Some states are considering and passing laws to protect consumer privacy as it relates to the use of their personal information. For example, California in June 2018 passed the California Consumer Privacy Act of 2018 (effective January 1, 2020), which protects consumers' right to: (1) know what personal information a for-profit business has collected about them, where it was sourced from, what it is being used for, whether it is being disclosed or sold, and to whom it is being disclosed or sold; (2) "opt out" of allowing a business to sell their personal information to third parties; (3) have a business delete their personal information, with some exceptions; and (4) receive equal service and pricing from a business, even if they exercise their privacy rights under the Act.[10] California's law does not apply to information covered by HIPAA, de-identified personal data, or aggregate consumer data, however, as long as the de-identification measures meet the Act's strict standards.[11]

What is de-identified patient data?

De-identified patient data is information about a patient or user of a health-related service that has been stripped of individually identifiable health information. Removing identifiers from PHI mitigates privacy risks to individuals and thereby supports the secondary use of data for comparative effectiveness studies, policy assessment, life sciences research, and other endeavors.[4] Information can be de-identified by either of two means: (1) a formal determination by a qualified expert (expert determination); or (2) the removal of specified individual identifiers and an absence of actual knowledge by the covered entity that residual information could be used to identify the individual (safe harbor).
The identifiers removed from PHI in the safe harbor method include:[4]

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
    - The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and
    - The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000
- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Fax numbers
- Device identifiers and serial numbers
- Email addresses
- Web URLs
- Social security numbers
- Internet Protocol addresses
- Medical record numbers
- Biometric identifiers, including finger and voice prints
- Health plan beneficiary numbers
- Full-face photographs and any comparable images
- Account numbers
- Any other unique identifying number, characteristic, or code, except as permitted
- Certificate/license numbers

How is de-identified data used?

De-identified data is used for research to derive information and knowledge about treatment and outcomes, as well as other patient care-related purposes. Outside of health care organizations and researchers, de-identified patient data is used by a variety of organizations and industries for various purposes, including many not related to patient care. De-identified data is sourced, collected, and used by a variety of organizations, including health care provider organizations such as hospitals or academic medical centers, and commercial enterprises such as personal genomics and biotechnology companies. Pharmaceutical manufacturers and retail pharmacies may also find use in de-identified health data to target their advertising. Health care providers use this data typically in research or the direct care of patient populations. The data can also be used to help reduce costs of care, improve treatment options, and support public health initiatives.

Machine learning is a family of methods used by some health care and data solution organizations to help predict certain outcomes and better prepare for and treat patients identified to be at risk. Machine learning models establish predictive rules using vast amounts of computing power. The more data a machine learning model has, the more complex the rules and the more accurate the predictions.[12] However, machine learning models are vulnerable to biases induced by data that does not adequately represent the patient population, such as data collected from only one institution or one geographic region. In order to develop clinical decision support tools that can be effectively used to treat the diverse patient populations in the United States, large amounts of data are

required, and often data from many different providers across the country are required to avoid bias. This data is often sourced from de-identified or anonymized patient records. Allscripts, for example, used 50 million de-identified patient records, and the application of an advanced machine learning algorithm, to "train" its systems and further improve its clinical decision support tools.[13] Organizations like Orion Health and Precision Driven Health are using datasets like these to generate machine learning aimed at improving health care decisions, and driving operational and cost efficiencies.[12, 14] By combining multiple datasets, such as behavioral data, device use data, patient claim data and socioeconomic and geographic data, these organizations are developing advanced predictive analytics to further improve precision health care.[14] The data used for the purposes of data mining and honing machine learning algorithms are either sourced and used at the organizational level, or de-identified or anonymized when used for external research, such as the analysis done by Allscripts. Data may be sourced via publicly available de-identified datasets, databases established through collaborative research agreements, or via the purchase of bulk de-identified data, on an exclusive or non-exclusive basis. Since this technology is relatively new in the health care space its implications for patient data are not well-studied. As artificial intelligence and advanced machine learning proliferate in the health care space, the value and number of potential uses of patient health data will inevitably increase. Stakeholders should be prepared for increasing concerns about related patient privacy and data security.

Commercial entities, such as personal genomics companies, may collect data to deliver genetics information to subscribers and then subsequently sell the de-identified data to another entity for another purpose. For example, 23andMe, a genomics and biotech service, sells de-identified user data to pharmaceutical companies that use it to conduct research on various diseases. Concerns arise in that when the data is de-identified, it is no longer considered PHI and therefore patient authorization or consent for use is not required and therefore not solicited—meaning that patients are not always aware how their data is being used.[1] For example, research using de-identified data such as biologic specimens may result in scientific knowledge that has commercial value. Proper consent for use and/or disclosure of commercial interest in this research is ideal but not always documented, sometimes resulting in legal action against physicians or researchers.[2]

In addition, there is a perceived lack of transparency and regulation in how patients' data is being sold, distributed, or used outside of their direct health care. Risk of re-identification, which some studies have demonstrated to be possible through matching data to other publicly available data sources, is another issue related to the use of de-identified data. There are also concerns about access to such information that is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment and/or prescribing behavior.

AMA POLICY

The AMA has multiple policies expressing its recognition of the importance of data privacy and protection of PHI, as well as policies expressing commitment to ensuring safe and appropriate use of de-identified data.

Board of Trustees Report 21-A-18, "Ownership of Patient Data," outlines federal and state laws that establish who owns a patient's medical records. The report also highlights the importance of ensuring patients have appropriate access to their data and physicians have the tools and controls they need to be good stewards of their patients' information while at the same time maintaining the ability to share information to seamlessly coordinate the best care. In support of these initiatives, the AMA has actively engaged with the U.S. Department of Health and Human Services (HHS), the Office of Inspector General, the Office of Civil Rights, and the Office of the National

Coordinator for Health Information Technology (ONC), and has broad policy in place covering all aspects of patient record maintenance, access and control.

AMA Policy H-315.978, "Privacy and Confidentiality," states that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

AMA Policy H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," expresses the AMA's commitment to advocating that physicians, as trusted stewards of PHI, should be the owners of all patient claims data and de-identified aggregate data that is established and maintained by the physician practice, specifically including data stored in the electronic health record or practice management system. The policy establishes principles around the use of these data that include compliance with HIPAA, requires physician consent for analysis of the data, and requires data to remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that whenever possible, medical records should be de-identified for purposes of use for utilization review, panel credentialing, quality assurance, and peer review. This policy also states our AMA will 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, and that whenever possible, de-identified data should be used for these purposes. Policy H-315-983 posits that in the event of a sale or discontinuation of a medical practice, 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. This policy includes extensive language emphasizing the AMA's commitment to protecting PHI, and that it will 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 physician 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.

In Policy H-315.975, "Police, Payer, and Government Access to Patient Health Information," the AMA commits to advocating for narrow and clearly defined bounds for the appropriate use of patient information by law enforcement, payers and government entities, for operations that cannot be reasonably undertaken with de-identified data. AMA Policy H-315.987, "Limiting Access to Medical Records," further defines who should and should not have access to this information.

The AMA's Code of Medical Ethics includes an opinion on "Access to Medical Records by Data Collection Companies." Opinion E-3.2.4 asserts that disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship. The opinion further expresses that physicians who wish to permit third-party access to *specific patient information* for commercial purposes should: (a) only provide data that has been de-identified, and

(b) fully inform each patient whose record would be involved about the purpose(s) for which access would be granted. This opinion, with respect to requests for permission to allow access to or disclose a *full medical record*, prohibits disclosing identifiable information for commercial purposes *without obtaining consent* from the patient to do so.

The authors of Resolution 3-A-18, which established policy D-315.975 and is the subject of this report, expressed particular concern that this Code of Medical Ethics Opinion may contradict itself in its emphasis on informing the patient of how their de-identified data will be used and the subsequent emphasis on the importance of obtaining consent. The key difference between the two elements of the opinion lies in the description of the patient information being requested (specific, de-identified patient information vs. full medical record), thus our AMA does not agree that these statements are contradictory.

The authors also expressed that this Opinion may be in disharmony with the rules set forth in the HIPAA Privacy Rule, specifically stating that authorization, rather than consent, is sometimes mandated for the release of PHI when being requested for purposes not related to treatment, payment, or health care operations (TPO). HIPAA defines three such uses or disclosures for which written authorization of the patient is required: (1) use and disclosure of psychotherapy notes; (2) use and disclosure of PHI for marketing; and (3) any sale of PHI.

Ethical Opinion E-3.2.4 was originally issued in 1994 and updated in 1998, prior to the enactment of the HIPAA Privacy Rule, yet provides an even higher standard than the Rule with respect to requirements for consent to disclose patient data, including data that has been de-identified. With respect to authorization requirements, Opinion E-3.2.4 does not include a statement about when authorization, rather than consent, is appropriate and/or required. Guidance provided in the Code of Ethics is provided by standards of conduct that define the essentials of honorable behavior for the physician. They cover broad ethical principles and are not intended to align with law or specific regulations that may be legally enforceable. During a comprehensive eight-year modernization process that ended in 2017, the AMA *Code of Medical Ethics* was reviewed for relevance/timeliness of guidance, clarity, and consistency of guidance. Opinion E-3.2.4 was reorganized in this process, taking the HIPAA provisions into consideration during the process. Care was taken to ensure the Council on Ethical and Judicial Affairs was conservative in suggesting substantive change, doing so only where needed to ensure that guidance remains relevant in the face of changes in biomedical science and conditions of medical practice. No contradictions or points of discord with HIPAA were identified in that review.

DISCUSSION

Oversight of patient information

The use of de-identified patient data is not heavily regulated. The HIPAA Privacy Rule does not restrict the use or disclosure of de-identified health information, since it is not considered PHI.[2, 5] HIPAA permits secondary uses of de-identified data for purposes such as public health initiatives, research, law enforcement, and other public interest endeavors.[5, 15] In addition, commercial entities that sell or use de-identified data, such as biotech and pharmaceutical companies, are not considered covered entities under HIPAA. Through their interactions with pharmacy benefit managers, pharmacies, payers, physicians and patients, however, they are indirectly impacted by privacy rules and must structure their transactions, projects, and internal data programs such that their partners that are covered entities or business associates thereof meet data privacy requirements under HIPAA and any other applicable standards.

Studies that use de-identified data are exempt from regulations that govern human subject research.[2, 16] Entities that collect and use consumer data, such as pharmaceutical companies or academic institutions conducting research, should employ privacy protections into their practices, such as data security, reasonable collection limits, sound retention and disposal practices, and data accuracy to protect privacy, as guided in recommendations from the Federal Trade Commission (FTC).[17] For example, Harvard University, like many academic institutions receiving federal grants, implements strict policy to govern the collection, storage and use of research data, including PHI.[18] In addition to the enforcement of strict policy, all human subjects research is subject to approval by the institution's Institutional Review Board (IRB). It is the responsibility of IRBs to specify the security level for research projects they review and approve, obtain confirmation that the relevant security controls are being implemented and decide if the human subject must give consent or in the case of de-identified information, approve the research under an exempt status from obtaining the consent.

Human subject research conducted or supported by certain federal departments or agencies is governed by the Federal Policy for the Protection of Human Subjects ("Common Rule"). Revisions to the Common Rule in 2017 were adopted in response to shifts in science, technology, public engagement, and public expectations that have raised concerns about the limitations of the existing ethical framework in research.[19] The rapid pace of change in the availability, utility, and value of patient data, including PHI and de-identified data, will continue to necessitate regular reconsideration of the ethical oversight of patient data and how it is protected by researchers and other entities.

Risks and ethical concerns

There are ethical concerns about the disclosure and use of de-identified health data that are rooted in the risk of re-identification. Studies have shown that certain elements of patient records, although not exclusive or unique to individual patients, increase the risk of re-identification if not removed from individual-level data.[20, 21] Elements such as gender, date of service, date of birth or zip code can potentially be linked back to other sources of data, such as voter registration lists, and could put the data at risk of re-identification.[21, 22] Organizations that collect, store, transfer and distribute de-identified data should take steps to reduce this risk, such as replacing a specific date of birth or date of service with a year.

Studies have been undertaken to assess the risk of re-identification after steps have been taken to de-identify the data, and have found gaps that can put de-identified patient health data at risk of being re-identified.[20, 23, 24] While these findings are significant and should not be ignored, one review of some of these studies concluded that many of them were small and did not use data that was de-identified according to existing standards (those set forth in the HIPAA Privacy Rule), so caution should be taken when making generalizations based on the few cases identified in the studies.[25]

In addition to risk of re-identification, there are general ethical concerns with the availability and use of patient health data, even if it's de-identified, without explicit authorization from patients. For example, pharmaceutical companies may use de-identified data to target marketing or advertising efforts to specific physicians, therefore influencing treatment plans for patient populations with specific diseases or conditions. Accountable Care Organizations (ACOs), as business associates of the ACO participants or a covered entity, may use de-identified data to analyze quality measures, population risk scores and patient behaviors.[26] Other for-profit entities may use de-identified data for the development of new technology or clinical innovations. These sales of patient records for profit by provider organizations may raise concerns from the public that providers have an ulterior

motive for collecting their data during clinical encounters. In addition, patient record licensing contracts with exclusive rights may raise questions about the appropriate stewardship of patient data, as such exclusive contracts may be seen to benefit specific licensees at the expense of others, rather than enabling research and product development across the entire marketplace.

Consent and authorization

Issues that arise in the potential risks of patient data use can be mitigated by proactively obtaining appropriate authorization or consent from patients for the use of their data. These issues primarily apply to PHI covered under HIPAA, however, and not de-identified data. The HIPAA Privacy Rule permits, but does not require, a covered entity voluntarily to obtain patient consent for uses and disclosures of PHI for TPO. Covered entities that decide to obtain consent have complete discretion to design a process that best suits their needs. By contrast, an authorization is required by the Privacy Rule for most uses and disclosures of PHI not otherwise allowed by the Rule. Where the Privacy Rule requires patient authorization, voluntary consent is not sufficient to permit a use or disclosure of PHI. An authorization is a detailed document that gives covered entities permission to use PHI for specified purposes (e.g., sale or marketing of PHI) or to disclose PHI to a third party specified by the individual. An authorization must include a number of elements, including a description of the PHI to be used and disclosed, the person authorized to make the use or disclosure, the person to whom the covered entity may make the disclosure, an expiration date, and, in some cases, the purpose for which the information may be used or disclosed.[27]

PHI may be used and disclosed for research without an authorization in limited circumstances: (1) Under a waiver of the authorization requirement; (2) as a limited data set with a data use agreement; (3) preparatory to research; and (4) for research on decedents' information. Limited data sets exclude 16 categories of direct identifiers, rather than the 18 identifiers removed in de-identified data. The information in a limited data set is considered PHI and its use or disclosure requires a data use agreement between the covered entity and the entity that will receive or use the data.

Non-covered entities that use de-identified health data for purposes such as genomics services or research are not regulated under HIPAA, but most have policies and procedures in place to protect the privacy of their subscribers or participants, and to ensure transparency in the use of the data. 23andMe, for example, obtains personal information from its subscribers and through its service identifies genetic information that is stored within its databases. According to its Privacy Policy, 23andMe "implements physical, technical, and administrative measures to prevent unauthorized access to or disclosure of your information, to maintain data accuracy, to ensure the appropriate use of information, and otherwise safeguard your Personal Information."[28] Subscribers can voluntarily consent to allow their information to be used in research, and can also choose what level of de-identified data they consent for use. 23andMe stores and allows access to both aggregate and individual level data to third-party service providers such as marketing and analytics organizations and targeted advertising service providers that contribute to the service provided by 23andMe. It also sells de-identified user data to pharmaceutical companies for the purposes of research.

Other entities may use anonymous, de-identified data in manners that are legal but may be perceived as ethically questionable since they may not have obtained patient consent for the use of the data. For example, a startup artificial intelligence business, funded by executives at a cancer center, has received exclusive access to the cancer center's database of millions of tissue slides.[29] The cancer center holds an equity stake in the organization along with two of its top leaders, and other board members are initial investors in the new venture. The company's leadership indicated that some patients had provided consent for the use of their data, others did not and their data was

subsequently stripped of its identifying factors. Still, pathologists at the cancer center, and their patients, have expressed concern about the potential conflict of interest in the cancer center leadership's relationship with the startup, as well as the use of patient data for a profit-driven venture. In this case, it was reported that the enterprise had been reviewed and approved by an IRB.[29]

Standards and guidance

ONC publishes the "Guide to Privacy and Security of Electronic Health Information" to help physicians, other health care providers and practices work to comply with federal requirements in collecting, storing and using patients' data.[30]

In addition to the policy set by the AMA and the guidance provided in the AMA *Code of Medical Ethics*, other physician and health care organizations provide guidelines and standards on the use of de-identified patient data. For example, the American Academy of Family Physicians published a "Data Stewardship" policy that facilitates the appropriate collection, storage, transmission, analysis, and reporting of de-identified patient data.[31] This policy includes guidance on establishing and maintaining a proper patient and physician consent process, as well as the appropriate use of data by third parties and policies that establish requirements for third party use.

The American College of Physicians (ACP) policy encourages clinical entities and physicians to publish electronically their policies and procedures for sharing patient data and ensuring privacy. ACP's policy also states that in keeping with HIPAA, patients should know what information exists about them, its purpose, who can access and use it, and where it resides. While ACP supports the use of appropriately de-identified patient data for socially important activities, such as population health efforts and retrospective research, it does recommend tighter controls on the risks of re-identification of de-identified data.[32]

CONCLUSION

Access to de-identified patient data is important for the future of health care. Its benefits to the field of research have significant implications for our ability to make progress in refining the practice of medicine, reducing health care costs, reducing and preventing chronic disease, identifying cures for deadly conditions, and much more. In practice-level interventions, de-identified data can help practice administrators recognize patterns and gaps in processes and treatment plans across clinicians. In the genomics and biotechnology fields the study of patient data, stripped of identifying factors, can contribute to global innovation in medical technology and pharmaceutical solutions. There are numerous ways in which the use of de-identified patient data contributes to the continuum of improvement that is much needed across health care.

Its use does not come without risks, however. In 1951, the development of the HeLa cell line led to many significant research accomplishments in medicine. However, the lack of patient consent in the development of the cell line raises serious ethical concerns, which were further compounded by the commercial use of the cell line for profit, which was not shared with the patient or her family. Though in recent times, substantial effort has been made to correct this historical wrong by the National Institutes of Health and other organizations, much of the harm done to patients who's clinically obtained samples were used without consent can never be undone. Today, a new revolution in health science powered by big data is in process, and there is little doubt that the research accomplishments derived from this data will transform the practice of medicine. However, all stakeholders involved now have an opportunity to ensure that there is not a repeat of the ethical mistakes of the past. Risk mitigation is the responsibility of all stakeholders, from the individual

clinician and patient to the administrators and third-party data users. The privacy and security of the patient data must be protected at every point, and its use needs to be ethically conducted with the appropriate level of consent or authorization required. The HIPAA provisions, regulations enacted at the state level, and organizational policies and procedures, ensure compliance with standards developed to protect the patient. If followed appropriately, these measures can effectively protect patient data from misuse.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm Policies H-315.974, "Guiding Principles, Collection and Warehousing of Electronic Medical Record Information," H-315.983, "Patient Privacy and Confidentiality," H-315.975, "Police, Payer, and Government Access to Patient Health Information," H-315.978, "Privacy and Confidentiality," and H-315.987, "Limiting Access to Medical Records." (Reaffirm HOD Policy)

2. That our AMA support state-based efforts to protect patient privacy including the patient's right to know whether information is being disclosed or sold and to whom and the right to opt out of the sale of their data. (New HOD Policy)

3. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information in light of new practices regarding de-identified patient data, including the use of exclusive de-identified data licensing agreements in healthcare. (Directive to Take Action)

4. That Policy D-315.975, "Research Handling of De-Identified Patient Information," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Fiscal note: Minimal – Less than $500

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-19

Subject:	Clarification to the Bylaws: Delegate Representation, Registration and Credentialing
Presented by:	Jerome C. Cohen, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

It has come to the Council's attention that several bylaw provisions relating to representation, registration and credentialing of AMA delegates and alternate delegates are ambiguous. The Council on Constitution and Bylaws, consistent with its functions enumerated in the Bylaws, has reviewed the Bylaws and proposed changes for consideration by the House of Delegates to provisions that are inconsistent and/or lack clarity.

DELEGATE REPRESENTATION

Our AMA House of Delegates, per Article IV of the AMA Constitution, is the legislative and policymaking body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The Council believes that an underlying premise of the various AMA bylaw provisions governing House of Delegates representation is that one can only represent an organization of which he/she is a member. Bylaw 2.0.1.2 speaks to the multi-dimensional role of delegates, including representation of the perspectives of the delegate's sponsoring organization, and Bylaw 2.10.3, "Lack of Credentials" alludes to the need for "proper identification as the delegate or alternate delegate selected by the respective organization." Nowhere, however, is membership in the organization being represented explicitly stated. Bylaw 2.0.1.1, "Composition and Representation," notes only that members of the House of Delegates must be active members of the AMA, but does not specify a requirement for membership in the organization being represented. Alternate delegates (who are not considered members of the House of Delegates) also are required to be AMA members, with nothing said about membership in the organization being represented.

The Council has proposed changes to several bylaws to clarify to delegates, alternate delegates and those with responsibility for certifying them, that AMA membership and membership in the organization being represented is mandatory.

DELEGATION PREREGISTRATION/CREDENTIALING

A delegate registration or certification process is essential in a democratic organization to ensure that only those entitled to vote may do so, and that they each vote only once. Existing AMA bylaws use different terminology to identify the key individual(s) responsible for certifying the organization's delegates. Our AMA Bylaws for constituent associations and the national medical specialty societies accord certification responsibility to the entity's president or secretary, while the bylaws for the AMA sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical

Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; professional interest medical associations; and the AMA sections put the onus for certification on the president, secretary or other authorized individual. With respect to the regional medical student delegates and the delegates from the Resident and Fellow Section, the MSS or RFS chairs are responsible for certifying their respective delegates and alternate delegates, although the RFS bylaws further allow its chair to delegate the task, a provision that the MSS would welcome.

The Council has proposed amendments to several bylaw provisions to make the language more consistent across the different groups represented in our House of Delegates. While a president is recognized as the representative of any organization, certain duties/responsibilities may be delegated. In practicality, it is typically the executive director or other staff person who confirms a society's credentialed representatives to the House of Delegates.

ONSITE CREDENTIALING/REGISTRATION

Our AMA Bylaws state that "certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates" and the Office of the House of Delegates Affairs works diligently with the Federation to ensure that delegate and alternate delegate certifications are received in a timely fashion. The names of the credentialed delegates and alternate delegates then become part of the Official Call, which is disseminated to all House of Delegates representatives, included in the House of Delegates Handbook, and serves as a starting point for a final list which is then published in the meeting proceedings. Nevertheless, there are always credentialed individuals who find themselves unable to attend the meeting, often at the last moment, so advance and onsite substitution of representatives occurs with some frequency. Bylaw 2.10.4 addresses the use of a "substitute delegate" when a delegate or alternate delegate is unable to attend a meeting, and Bylaw 2.10.4.1 provides for "a temporary substitute delegate" when a delegate is not able to remain in attendance for the entire meeting. Last, Bylaw 2.10.3, Lack of Credentials, permits a delegate or alternate delegate to be seated/credentialed onsite provided proper identification as the delegate or alternate delegate selected by the respective organization is established and so certified to the AMA.

The Council has heard concerns about the onsite credentialing and recredentialing processes, particularly after the opening of the House of Delegates. At the 2018 Annual Meeting of the House of Delegates, there were some 31 onsite delegate certifications/substitutions – 12 from constituent associations, 11 from the national medical specialty societies and professional interest medical associations, 4 medical student regional delegates and 4 RFS sectional delegates. Additionally, there were 36 onsite delegate certifications/substitutions of alternate delegates (6 of which were regional medical student delegates and 9 of which were RFS sectional delegates). At the 2018 Interim Meeting, there were 35 onsite delegate certifications/substitutions – 11 from constituent associations, 15 from the national medical specialty societies and professional interest medical associations, 7 RFS sectional delegates, and 2 regional medical student delegates. Additionally, there were 23 onsite alternate delegate certifications/substitutions (of which 2 were regional medical student delegates and 5 were RFS sectional delegates).

To minimize disruption and provide clarity, the Council is proposing to modify 2.10.4. and subprovisions which speak to the formal recredentialing process and the timing of such. The Council believes that the intent of Bylaw 2.10.4.1 as written was to allow an individual <u>initially credentialed as an alternate delegate</u> (or substitute alternate delegate) to be <u>recredentialed</u> as a delegate in a delegate's absence. To provide a time frame, the Council has chosen "the first meeting of the Committee on Rules and Credentials" (Saturday morning before the opening session

of the House of Delegates) as a defined point in time by which the names and credentials of all delegates and alternate delegates can be finalized. At each House of Delegates meeting, each delegate receives a delegate badge with an appropriate ribbon, plus an additional credential that can be given to an alternate delegate should the delegate need to be out of the room at the time a vote is taken. If the delegate must leave the meeting, the delegate may formally transfer his credentials to either an alternate delegate or a (previously credentialed) substitute alternate delegate at the registration area.

PARITY

The House of Delegates has placed great emphasis on the need for parity between the constituent societies and the national medical specialty societies, and the Council, in looking at the bylaws that address registration and seating of delegates, noted an inequity. Bylaw 2.10.5 states that the current president of a constituent association may be certified as an additional alternate delegate at the discretion of each constituent association. The Council noted that there is no corresponding bylaw whereby a national medical specialty society or a professional interest medical association can achieve that. To accord the same opportunity to a national medical specialty society or a professional interest medical association to credential its president as an alternate delegate, the Council has proposed an equivalent bylaw to ensure parity and to potentially minimize vacant delegate seats for these entities.

Because of some concerns about unnecessarily swelling the size of the House, the Council looked at the registration and credentialing lists from the 2018 Annual and Interim meetings. For the A-18 meeting, there were 13 delegate vacancies from 7 national medical specialty societies or professional interest medical associations, and 101 alternate delegate vacancies from 54 societies, contrasted with only 1 constituent society with a delegate vacancy and 45 alternate delegate vacancies from 15 constituent societies. For the I-18 meeting, there were 23 delegate vacancies from 23 national specialty societies or professional interest medical association, contrasted with 5 delegate vacancies from 4 constituent societies and 62 alternate delegate vacancies from 23 constituent societies. Thus, the Council's proposed provision to extend the same courtesy to presidents of a national medical specialty society and professional interest medical association will likely not result in any significant increase in credentialed alternate delegates.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted; and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw.

2.0.1.1 Qualification of Members of the House of Delegates. Members of the House of Delegates must be active members of the AMA and of the entity they represent.

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2.1 Constituent Associations. Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be

provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

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2.1.4 Certification. The president ~~or secretary~~ of each constituent association or the president's designee shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

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2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1.1 using methods specified in AMA policy.

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2.2.4 Certification. The president ~~or secretary~~ of each specialty society or the president's designee shall certify to the AMA the delegates and alternate delegates from their respective societies. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

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2.3 Medical Student Regional Delegates. ~~In addition to the delegate and alternate delegate representing the Medical Student Section, regional~~ ~~M~~medical student regional delegates and alternate delegates shall be apportioned and elected as provided in this bylaw. Medical student regional delegates and alternate delegates represent the constituent association that endorsed their candidacy pursuant to bylaw 2.3.3.

2.3.1 Qualifications. Medical ~~S~~student ~~R~~regional delegates and alternate delegates must be active medical student members of the AMA and attend medical school in the medical student region from which they seek election. In addition, medical student regional delegates and alternate delegates must be members of the constituent association in the state wherein their educational program is located.

2.3.1.1 Medical student regional alternate delegates may substitute for delegates in their same region in accordance with 2.8.5 and 2.10.4.

2.3.2 Apportionment. The total number of ~~M~~medical ~~S~~student ~~R~~regional delegates and alternate delegates is based on one delegate and one alternate delegate for each 2,000 active medical student members of the AMA, as recorded by the AMA on December 31 of each year. Each ~~M~~medical ~~S~~student ~~R~~region, as defined by the

Medical Student Section, is entitled to one delegate and one alternate delegate for each 2,000 active medical student members of the AMA in an educational program located within the jurisdiction of the ~~M~~medical ~~S~~student ~~R~~region….***

2.3.3 Election. Medical ~~S~~student ~~R~~regional delegates and alternate delegates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate must receive written endorsement from the constituent association representing the jurisdiction within which the medical student's educational program is located, in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected at the Business Meeting of the Medical Student Section prior to the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

2.3.4 Certification. The Chair of the Medical Student Section Governing Council or the Chair's designee shall certify to the AMA the delegates and alternate delegates ~~for~~ from each ~~M~~medical ~~S~~student ~~R~~region. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.

2.4 Delegates from the Resident and Fellow Section. In addition to the delegate and alternate delegate representing the Resident and Fellow Section, resident and fellow physician delegates and alternate delegates shall be apportioned and elected in a manner as provided in this bylaw.

2.4.1 Qualifications. Delegates and alternate delegates from the Resident and Fellow Section must be active members of the Resident and Fellow Section of the AMA. In addition, resident and fellow physician delegates and alternate delegates must be members of their endorsing constituent association, national medical specialty society, federal service or professional interest medical association.

2.4.2 Apportionment. The apportionment of delegates from the Resident and Fellow Section is one delegate for each 2,000 active resident and fellow physician members of the AMA, as recorded by the AMA on December 31 of each year.

2.4.3 Election. Delegates and alternate delegates shall be elected by the Resident and Fellow Section in accordance with procedures adopted by the Section. Each delegate and alternate delegate must receive written endorsement from ~~his or her~~ a constituent association, ~~or~~ national medical specialty society, federal service or professional interest medical association in accordance with procedures adopted by the Resident and Fellow Section and approved by the Board of Trustees.

2.4.4 Certification. The Chair of the Resident and Fellow Section Governing Council or ~~his or her~~ the Chair's designee shall certify to the AMA the delegates and alternate delegates for the Resident and Fellow Section. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates.

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2.6 Other Delegates. Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates.

2.6.1 Certification. The president~~, secretary~~ or other authorized individual of each entity shall certify to the AMA their respective delegate and alternate delegate. Certification must occur 30 days prior to the Annual or Interim Meeting.

2.8 Alternate Delegates. Each organization represented in the House of Delegates may select an alternate delegate for each of its delegates entitled to be seated in the House of Delegates.

2.8.1 Qualifications. Alternate delegates must be active members of the AMA and of the entity they represent.

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2.8.5 Rights and Privileges. An alternate delegate may substitute for a delegate~~,~~ on the floor of the House of Delegates, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials. While briefly substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote on all matters other than elections. If a delegate needs a substitute for more than half a day, then an alternate delegate must be properly recredentialed as the delegate in accordance with Bylaw 2.10.4. An alternate delegate who has been properly recredentialed as the delegate in accordance with Bylaw 2.10.4 is then considered a member of the House of Delegates, with all the rights and privileges of a delegate.

2.8.6 Status. The alternate delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. ~~The~~ An alternate delegate must immediately relinquish his or her position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is briefly substituting.

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2.10 Registration and Seating of Delegates.

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2.10.2 Credentials. A delegate or alternate delegate representing a constituent association or a national medical specialty society may only be seated if there is ~~Before being seated at any meeting of the House of Delegates, each delegate or alternate delegate shall deposit with the Committee on Rules and Credentials~~ a certificate on

file submitted ~~signed~~ by the president~~,~~ or the president's designee. ~~secretary, or~~ A delegate or alternate delegate representing a section, federal service or professional interest medical association may only be seated if there is a certificate on file submitted by the section chair or other authorized individual. All certificates must ~~other authorized individual of the delegate's or alternate delegate's organization~~ state~~ing~~ that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.

2.10.3 Lack of Credentials. A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective organization is established, and so certified to the AMA by the organization's president, the president's designee or other authorized individual.

2.10.4 Substitute. When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the ~~appropriate authorities~~ president, the president's designee or other authorized individual of the organization or section may appoint a substitute delegate or substitute alternate delegate prior to the first meeting of the Committee on Rules and Credentials, who ~~on presenting proper credentials~~ shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting.

2.10.4.1 Temporary Substitute Delegate. A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must ~~comply with the formal recredentialing procedures established by the Committee on Rules and Credentials for such purpose~~ have a certification on file submitted by the president, the president's designee or other authorized individual of the organization or Section, and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.10.5 Constituent Association President. The current president of a constituent association may also be certified as an additional alternate delegate at the discretion of each constituent association. Certification must occur at least 30 days prior to the Annual or Interim meeting of the House of Delegates.

2.10.6 President of a National Medical Specialty Society or Professional Interest Medical Association. The current president of a national medical specialty society or professional interest medical association may also be certified as an additional

alternate delegate at the discretion of each national medical specialty society and professional interest medical association with representation in the House of Delegates. Certification must occur at least 30 days prior to the Annual or Interim meeting of the House of Delegates.

2.10.~~6~~7 Representation. No delegate or alternate delegate may be ~~registered~~ credentialed or seated at any meeting to represent more than one organization in the House of Delegates.

2.10.~~7~~8 Medical Student Seating. Each ~~M~~medical ~~S~~student ~~R~~regional delegate shall be seated with the constituent association representing the jurisdiction within which such delegate's educational program is located.

2.10.~~8~~9 Resident and Fellow Seating. Each delegate from the Resident and Fellow Section shall be seated with the physician's endorsing constituent association, ~~or~~ specialty society, federal service or professional interest medical association. In the case where a delegate has been endorsed by multiple associations ~~both a constituent association and specialty society~~, the delegate must choose, prior to the election, with which delegation the delegate wishes to be seated.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-A-19)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-19

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William C. Reha, MD, MBA, Chair)

The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians' technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council's purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" and as "developmental, impermanent, and context dependent" [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

FROM SELF-ASSESSMENT TO "INFORMED" SELF-ASSESSMENT

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians' "individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles" [11].

Self-assessment has thus become "integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students" [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5,10,13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5,12,13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers' performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5,12,17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12,18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors' perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment tools alone are not sufficient measures of physicians' ability to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, "The road to self-knowledge may run through other people" [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20].

They may also question the accuracy and credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued both by those being assessed and by those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews ("360° reviews"), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and "provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies" [22]. Beyond such formal mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

One study among physicians and physicians in training found that participants used a dynamic, multidimensional process to assess their own abilities. Under this process of what researchers identified as "informed self-assessment," participants interpreted and responded to multiple types of information, such as cognitive and affective data, from both formal and informal sources [23]. Participants described "critically reflecting 'in action,' that is, during an activity or throughout the day:"

> I think we do a lot of it without thinking of it as reflection. We do it every day when we look at a patient's chart. You look back and see the last visit, "What did I do, or should I have done something different?" I mean that's reflection, but yet I wouldn't have thought of that as self-assessment or self-reflection, but we do it dozens of times a day [23].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians' thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27]. Prevailing theory distinguishes "fast" from "slow" thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [26]. Some scholars take expertise to involve "fast" processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [24]. Others argue that expertise consists in using "slow," effortful, analytic processes to address problems [24]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment ("situational awareness") and can determine when to shift to effortful processes [24].

Expert judgment is the ability "to respond effectively in the moment to the limits of [one's] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed" [24], a practice described as "slowing down." Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must "vigilantly monitor relevant environmental cues" and use these as signals to slow down, to

transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education, training, and experiences that provide tools with which to shape their clinical reasoning. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Heuristics

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [28], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [28]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [28,29,30].

Habits of Perception

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [31]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

Overconfidence

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [28,30]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one's abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one's limits [28,30].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [28]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

Physicians' ability to practice safely can be affected by their own health, of course. The *Code of Medical Ethics* addresses such situations in guidance on physicians' health and wellness (E-9.3.1) and their responsibilities to impaired colleagues (E-9.3.2).

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that "should be accepted as forever outside one's scope of competent practice" [32]. Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence" and to "set appropriately challenging learning goals" that push the boundaries of the physician's knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in

the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to "slow down" during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the "prospective memory"—i.e., "a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so"—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one's knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians' self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for "mindful" practice, is an essential marker of competence broadly understood:

> Safe practice in a health professional's day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient . . . . This decision making in context is importantly different from being able to accurately rate one's own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing 'reflection-in-practice,' addressing emergent problems and continuously monitoring one's ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be "good" practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to "know when to slow down" in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one's practice is that, unlike standardized examinations, they are drawn from one's actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one's communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician's practice lifetime [38]. It enables physicians to "integrate personal beliefs, attitudes, and values in the context of professional culture," and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [38].

"Mindful practice," that is, being fully present in everyday experience and aware of one's own mental processes (including those that cloud decision making) [39], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [39].

"Exemplary physicians," one scholar notes, "seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values" [39].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills. However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from

medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

(a) Cultivate continuous self-awareness and self-observation.

(b) Recognize that different points of transition in professional life can make different demands on competence.

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.

(d) Seek feedback from peers and others.

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.

(f) Intervene in a timely and appropriate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physicians' responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.

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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-19)
Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The House of Delegates asked the Council on Ethical and Judicial Affairs (CEJA) to "study the issue of aid in dying with consideration of data collected from the states that currently authorize aid-in-dying, and input from some of the physicians who have provided medical aid-in-dying to qualified patients. CEJA was further asked to consider the need to distinguish between "physician-assisted suicide" and "aid in dying."

In response to these requests, CEJA carried out an extensive review of relevant philosophical and empirical literature. Its deliberations have further been informed by an educational session at the 2016 Interim Meeting and consultations with stakeholders at the 2017 Annual and Interim meetings, as well as extensive correspondence from stakeholders within the medical community and the public at large. In addition, the council heard passionate testimony from both opponents and supporters of physician participation in assisted suicide at the 2018 Annual and Interim meetings.

Reflecting on this input, CEJA recognized that thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Importantly, the council found that despite deep differences, supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

CEJA interprets existing guidance in the AMA *Code of Medical Ethics* as encompassing the irreducible moral tension at stake for physicians with respect to participating in assisted suicide.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, CEJA recommends that the *Code of Medical Ethics* not be amended.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-19

Subject:	Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
Presented by:	James E. Sabin, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William C. Reha, MD, MBA, Chair)

At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, "Study Aid-in-Dying as End-of-Life Option," presented by the Oregon Delegation, which asked:

> That our American Medical Association (AMA) and its Council on Judicial and Ethical Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician "aid-in-dying."

At the following Annual Meeting in June 2017, the House of Delegates similarly referred Resolution 14-A-17, "The Need to Distinguish between 'Physician-Assisted Suicide' and 'Aid in Dying'" (presented by M. Zuhdi Jasser, MD), which asked that our AMA:

> (1) as a matter of organizational policy, when referring to what it currently defines as '*Physician Assisted Suicide'* avoid any replacement with the phrase '*Aid in Dying*' when describing what has long been understood by the AMA to specifically be '*Physician Assisted Suicide'*; (2) develop definitions and a clear distinction between what is meant when the AMA uses the phrase '*Physician Assisted Suicide'* and the phrase *'Aid in Dying'*; and (3) fully utilize these definitions and distinctions in organizational policy, discussions, and position statements regarding both '*Physician Assisted Suicide*' and '*Aid in Dying.*'

This report by the Council on Ethical and Judicial Affairs addresses the concerns expressed in Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed the philosophical and empirical literature, sought input from the House of Delegates through an I-16 educational program on physician-assisted suicide, an informal "open house" at A-17, and its I-17 Open Forum. The council wishes to express its sincere appreciation for participants' contributions during these sessions and for additional written communications received from multiple stakeholders, which have enhanced its deliberations.

The council observes that the ethical arguments advanced today supporting and opposing "physician-assisted suicide" or "aid in dying" are fundamentally unchanged from those examined

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

in CEJA's 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of Opinion E-5.7, "Physician-Assisted Suicide," in 1994.

"ASSISTED SUICIDE," "AID IN DYING," OR "DEATH WITH DIGNITY"?

Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal medication to be self-administered by patients in many ways reflect the different ethical perspectives that inform ongoing societal debate. Proponents of physician participation often use language that casts the practice in a positive light. "Death with dignity" foregrounds patients' values and goals, while "aid in dying" invokes physicians' commitment to succor and support. Such connotations are visible in the titles of relevant legislation in states that have legalized the practice: "Death with Dignity" (Oregon, Washington, District of Columbia), "Patient Choice and Control at the End of Life" (Vermont), "End of Life Options" (California, Colorado), "Our Care Our Choice Act" (Hawaii), and in Canada's "Medical Aid in Dying."

Correspondingly, those who oppose physician provision of lethal medications refer to the practice as "physician-assisted suicide," with its negative connotations regarding patients' psychological state and its suggestion that physicians are complicit in something that, in other contexts, they would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their use obscures or sanitizes the activity. In their view such language characterizes physicians' role in a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still others, meanwhile, argue that the choice by terminally ill patients to take action to end their own lives with the assistance of their physician is distinct from what is traditionally understood as "suicide" [4].

The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council's view, despite its negative connotations [5], the term "physician assisted suicide" describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

COMMON GROUND

Beneath the seemingly incommensurate perspectives that feature prominently in public and professional debate about writing a prescription to provide patients with the means to end life if they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of life. A vision that is characterized by hope for a death that preserves dignity, a sense of the sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the deepest aim of medicine, and fully voluntary participation on the part of both patient and physician in decisions about how to approach the end of life.

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying "with dignity" may mean accepting the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some

physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of Principle I of the AMA *Principles of Medical Ethics*: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."

So too, how physicians understand and act on the goals of relieving suffering, respecting autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and values that may not be commensurate. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different judgments about what is an ethically permissible course of action is profoundly challenging. With respect to physician-assisted suicide, some professional organizations—for example, the American Academy of Hospice and Palliative Medicine [6]—have adopted a position of "studied neutrality." Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are intended to respect that there are irreducible differences among the deeply held beliefs and values that inform public and professional perspectives [6,7], and to leave space open for ongoing discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither neutral or appropriate for organized medicine [8], and as being open to unintended consequences, including stifling the very debate it purports to encourage or being read as little more than acquiescence with the contested practice [9].

CEJA approaches the condition of irreducible difference from a different direction. In its 2014 report on exercise of conscience, the Council noted that "health care professionals may hold very different core beliefs and thus reach very different decisions based on those core beliefs, yet equally act according to the dictates of conscience. For example, a physician who chooses to provide abortions on the basis of a deeply held belief in protecting women's autonomy makes the same kind of moral claim to conscience as does a physician who refuses to provide abortion on the basis of respect for the sanctity of life of the fetus" [10].

Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on intuition or emotion. Rather, such decisions are based on "substantive, coherent, and reasonably stable" values and principles [10]. Physicians must be able to articulate how those values and principles justify the action in question.

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging "substantive, coherent, and reasonably stable" values and principles within the profession and the wider moral community. While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme

Court's advisory panel on physician-assisted death, "neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and nuanced understanding of how to best honor and address the needs of people who are suffering" [11].

THE RISK OF UNINTENDED CONSEQUENCES

From the earliest days of the debate, a prominent argument raised against permitting physician-assisted suicide has been that doing so will have adverse consequences for individual patients, the medical profession, and society at large. Scholars have cited the prospect that boundaries will be eroded and practice will be extended beyond competent, terminally ill adult patients; to patients with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting the practice will compromise the integrity of the profession, undermine trust, and harm the physicians and other health care professionals who participate; and that forces outside medicine will unduly influence decisions.

The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide, along with procedural and reporting requirements—can actually protect patients and sustain the integrity of medicine remains deeply contested. Some studies have "found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups" [12], others question whether the available data can in fact support any such conclusions, finding the evidence cited variously flawed [13], inadequate [14], or distorted [15].

Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [17]. For example, research in the Netherlands has found that "requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone," mitigating fears that "solitary, depressed individuals with potentially reversible conditions might successfully end their lives." At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent "reported only psychological suffering." At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a "slippery slope" [18].

Studies have also raised questions about how effective retrospective review of decisions to provide euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch regional euthanasia committees determined had not met legal "due care criteria" found that such reviews focus on procedural considerations and do not "directly assess the actual eligibility" of the patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients obtained euthanasia found that physicians' reports "stated that psychosis or depression did or did not affect capacity but provided little explanation regarding their judgments" and that review committees "generally accepted the judgment of the physician performing EAS [euthanasia or physician-assisted suicide]" [20]. It remains an open question whether reviews that are not able to assess physicians' reasoning truly offer the protection they are intended to provide. To the extent

that reporting and data collection in states that permit physician-assisted suicide have similar limitations, oversight of practice may not be adequate.

Medicine must learn from this experience. Where physician-assisted suicide is legalized, safeguards can and should be improved—e.g., "[t]o increase safeguards, states could consider introducing multidisciplinary panels to support patients through the entire process, including verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all palliative and end-of-life options" [21]. Both the state and the medical profession have a responsibility to monitor ongoing practice in a meaningful way and to address promptly compromises in safeguards should any be discovered. It is equally important that strong practices be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health care organizations in California and Canada, for example, have shared richly descriptive reports of practices adopted in response to the recent legalization of "aid in dying" in those jurisdictions that seek to address concerns about quality of practice and data collection [22,23].

Medicine must also acknowledge, however, that evidence (no matter how robust) that there have not yet been adverse consequences cannot guarantee that such consequences would not occur in the future. As a recent commentary noted, "[p]art of the problem with the slippery slope is you never know when you are on it" [17].

SAFEGUARDING DECISIONS AT THE END OF LIFE

CEJA has found that just as there are shared commitments behind deep differences regarding physician-assisted suicide**,** there are also shared concerns about how to understand the available evidence. For example, in the council's recent Open Forum, both proponents and opponents of physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health care system in which patients have uneven access to care, including access to high quality end-of-life care. They also noted that patients and physicians too often still do not have the conversations they should about death and dying, and that too few patients are aware of the range of options for end-of-life care, raising concern that many patients may be led to request assisted suicide because they don't understand the degree of relief of suffering state-of-the-art palliative care can offer. Participants who in other respects held very different views concurred as well that patients may be vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed concern in common that forces external to medicine could adversely influence practice.

These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in America* [24]. They are concerns echoed in a February 2018 workshop on physician-assisted death convened by the National Academies of Science, Engineering and Medicine [25]. They underscore how important it is to understand *why* a patient requests assisted suicide as a starting point for care [26].

Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that are too often avoided. They open opportunities to explore the patient's goals and concerns, to learn what about the situation the individual finds intolerable and to respond creatively to the patient's needs other than providing the means to end life—by such means as better managing symptoms, arranging for psychosocial or spiritual support, treating depression, and helping the patient to understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients [28]. The profession also has a responsibility to advocate for adequate resources for end-of-life care [16,28], particularly for patients from

disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.

CONCLUSION

At the core of public and professional debate, the council believes, is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease" [27]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

RECOMMENDATION

The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the irreducible differences in moral perspectives identified above. The council recognized that supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but diverge in drawing different moral conclusions from those underlying values in equally good faith. The council further recognized that medicine must learn from experience of physician-assisted suicide, and must ensure that, where the practice is legal, safeguards are improved.

After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the *Code* offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient-physician relationship.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, the Council on Ethical and Judicial Affairs recommends that the *Code of Medical Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted, and that the remainder of the report be filed.[1]

Fiscal Note: None.

[1] CEJA plans to present E-5.7 and E-1.1.7 in online and print versions of the *Code of Medical Ethics* as suggested in the Appendix.

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APPENDIX

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics *encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.*

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and

committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; 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.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-19

Subject: CEJA's Sunset Review of 2009 House Policies

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William C. Reha, MD, MBA, Chair)

At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- Each year the House policies that are subject to review under the policy sunset mechanism are identified.
- Policies are assigned to appropriate Councils for review.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) sunset the policy; (c) retain part of the policy; d) reconcile the policy with more recent and like policy. A justification must be provided for the recommended action to retain a policy.
- A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. A reaffirmation or amendment to policy by the House of Delegates resets the sunset clock, making the reaffirmed or amended policy viable for another 10 years.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

2009 POLICIES

In this report, the Council on Ethical and Judicial Affairs (CEJA) presents its recommendations regarding the disposition of 2009 House policies that were assigned to or originated from CEJA.

DUPLICATIVE POLICIES

On the model of the Council on Long Range Planning & Development (CLRPD)/CEJA Joint Report I-01 and of subsequent reports of CEJA's sunset review of House policies, this report recommends the rescission of House policies issued since June 2009. As noted previously, the intent of this process is the elimination of duplicative ethics policies from PolicyFinder. The process does not diminish the substance of AMA policy in any sense. Indeed, CEJA Opinions are a category of AMA policy.

MECHANISM TO ELIMINATE DUPLICATIVE ETHICS POLICIES

The Council continues to present reports to the HOD. If adopted, the recommendations of these reports continue to be recorded in PolicyFinder as House policy. After the corresponding CEJA Opinion is issued, CEJA utilizes its annual sunset report to rescind the duplicative House policy.

For example, at the 2007 Interim Meeting, the HOD adopted the recommendations of CEJA Report 8-I-07, "Pediatric Decision-Making." It was recorded in PolicyFinder as Policy H-140.865. At the 2008 Annual Meeting, CEJA filed the corresponding Opinion E-2.026, thereby generating a duplicative policy. Under the mechanism to eliminate duplicative ethics policies, CEJA recommended the rescission of Policy H-140.865 as part of the Council's 2009 sunset report.

The Appendix provides recommended actions and their rationale on House policies from 2009, as well as on duplicate policies.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500.

APPENDIX - RECOMMENDED ACTIONS

Policy No.	Title	Recommended Action & Rationale
D-105.998	Direct to Consumer Advertising D-105.998	Rescind The goal of this directive was accomplished through AMA communication to the Food and Drug Administration. Policy H-105.988, Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices to which it refers remains in effect.
D-250.991	Victims of the War in Kosovo	Rescind. Policy is outdated. The goal of this directive was originally accomplished by the establishment of the Physician Opportunities Portal, which has been discontinued.
D-250.992	Medical Supply Donations to Foreign Countries	Rescind. Policy is outdated and duplicates efforts of the World Health Organization, which provides up-to-date international information and guidelines on humanitarian donations of medical supplies at https://www.who.int/hac/crises/hti/appeal/medical_supplies/en/.
D-315.994	Abuse of the Medical Record for Regulation or Financing the Practice of Medicine	Rescind The goal of this directive is accomplished through extensive materials available at https://www.ama-assn.org/search?search=confidentiality%2C+medical+records&sort_by=search_api_relevance
D-315.996	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	Rescind The goal of this directive is accomplished by extensive materials available at https://policysearch.ama-assn.org/policyfinder/search/HIPAA/relevant/1/
D-373.998	Guidelines for Handling Derogatory Conduct in the Patient-Physician Relationship	Rescind The goal of this directive was accomplished in AMA correspondence to the Joint

		Commission and directive is duplicative of E-1.2.2, Disruptive Behavior by Patients. This issue is currently under further consideration by the Council on Ethical and Judicial Affairs in response to Resolution 18-A-18.
D-460.974	Office for Human Research Protections Interpretation of 45 CFR Part 46	Rescind The goal of this directive was accomplished in AMA correspondence with the Office of Human Research Protections and has been superseded by the revised Common Rule (2017).
D-460.991	Interim Report of the Inter-Council Task Force on Privacy and Confidentiality	Rescind This directive is outdated and is superseded by the revised Common Rule (2017).
D-60.970	Disclosure of Health Status to Children and Adolescents	Rescind The goal of this directive was accomplished by amendments to E-2.1.1, Pediatric Decision Making, adopted in 2010, 2018.
D-70.954	Transition to ICD-10 Code Sets	Rescind The goal of this directive is accomplished by extensive material available at https://www.ama-assn.org/search?search=ICD-10
H-5.990	Policy on Abortion	Reaffirm
H-65.985	Inappropriate Federal Prosecution	Reaffirm
H-140.921	Preserving the Traditional Patient-Physician Relationship	Rescind Policy is outdated and duplicative of guidance in the modernized *Code of Medical Ethics* (2016): E-8.6, Promoting Patient Safety E-9.5.2, Staff Privileges E-10.1, Ethics Guidance for Physicians in Nonclinical Roles E-11.2.1 Professionalism in Health Care Systems E-11.2.2, Conflicts of Interest in Patient Care E-11.2.3, Contracts to Deliver Health Care Services E-11.2.4, Transparency in Health Care
H-140.926	Policy for Physician Entrepreneur Activity	Reaffirm
H-140.949	Physician-Assisted Suicide	Rescind

		Title is misleading in that this policy, originally adopted in 1996, focuses on palliative care, not physician-assisted suicide. AMA has subsequently developed extensive policy in this area: H-70.915, Good Palliative Care (2014) H-295.875, Palliative Care and End of Life Care (2006) H-85.951, Concurrent Hospice and Curative Care (2016) H-85.955, Hospice Care (2014) D-600.984 Specialty Organizations Seated in our AMA House of Delegates (2018), seating the American Academy of Hospice and Palliative Medicine E-5.1, Advance Care Planning (2010)
H-140.952	Physician Assisted Suicide	Reaffirm
H-140.951 H-140.996	Professionalism and Medical Ethics Reaffirmation of Professionalism **Professionalism and Medical Ethics H-140.951** The AMA ~~re~~affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state cannot legislate ethical standards or excuse physicians from their ethical obligations~~; and urges all physicians and other appropriate health professional organizations to make their views known to their state legislatures and governors.~~ **Reaffirmation of Professionalism H-140.996** Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.	Consolidate and retitle: **H-140.951 Professionalism in Medicine** Our AMA believes that the primary mission of the physician is to use his best efforts and skill in the care of his patients and to be mindful of those forces in society that would erode fundamental ethical medical practice. The AMA affirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state neither legislate ethical standards nor excuse physicians from their ethical obligations. The AMA House of Delegates, Board of Trustees, staff, and membership rededicate themselves to professionalism such that it permeates all activities and is the defining characteristic of the AMA's identity.
H-190.958	Readability of Medical Notices of Privacy Practices	Rescind AMA provides sample language for notice of privacy practices at

		https://www.ama-assn.org/practice-management/hipaa/hipaa-privacy-security-resources
H-315.997	Patients' Access to Information Contained in Medical Records	Rescind Policy is outdated. HIPAA mandates patient access to their medical records.
H-315.998	Medical Record Privacy	Rescind. Policy adopted in 1979 is superseded by more recent law and regulation. AMA model legislation on this issue is no longer publicly available.
H-350.971 H-350.975	Initiatives Regarding Minorities Improving Healthcare of Hispanic Populations in the United States	Defer recommendation to 2019 Interim meeting pending review by Chief Health Equity Officer. Consider consolidating these and other policies that address identified patient populations and health disparities: H-160.991 Health Care Needs of Gay, Lesbian, Bisexual and Transgender Populations H-295.878 Eliminating Health Disparities—Promoting Awareness and Education of Lesbian, Gay, Bisexual and Transgender (LGBT) Issues in Medical Education H-350.957 Addressing Immigrant Health Disparities H-350.958 Hispanic Population and Access to the US Healthcare System H-350.959 Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities H-350.961 Improving the Health of Minority Populations H-350.966 Health Initiatives on Asian-Americans and Pacific Islanders

		H-350.971 AMA Initiatives Regarding Minorities H-350.972 Improving the Health of Black and Minority Populations H-350.974 Racial and Ethnic Disparities in Health Care H-350.976 Improving Health Care of American Indians H-440.869 Establishment of State Commission/Task Force to Eliminate Racial and Ethnic Health Care Disparities D-350.996 Strategies for Eliminating Minority Health Care disparities D-55.997 Cancer and Health Care Disparities among Minority Women D-65.995 Health Care Disparities among Gay, Lesbian, Bisexual and Transgender Families
H-405.982	Medical Informatics - Policy Initiatives for the AMA	Rescind Superseded by AMA digital health resources at https://www.ama-assn.org/search?search=digital+health
H-515.967	Protection of the Privacy of Sexual Assault Victims	Reaffirm

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-19)

Introduced by: Illinois

Subject: Opposing Attorney Presence at and/or Recording of Independent Medical Examinations

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, An independent medical examination or IME (also known as a compulsory medical examination or CME) is an integral component used in civil litigation to resolve questions about a particular medical condition or care; and

Whereas, Recording, videotaping, or allowing the presence of a court reporter or opposing attorney during the IME can, simply by their presence, obstruct efforts to properly obtain medical information and can create an adversarial environment; and

Whereas, Courts are increasingly compelling physicians to agree to the above conditions as a condition to testifying; and

Whereas, No other professionals are compelled to agree to these conditions as a condition to testifying; and

Whereas, Any significant collateral medical issue discovered during the IME must be disclosed to the patient, and thus a partial patient-physician relationship actually does exist; and

Whereas, The recording of the IME is the property of the legal representative of the person being examined and can be used in future trials or venues as they see fit; therefore be it

RESOLVED, That our American Medical Association amend Policy H-365.981, “Workers’ Compensation,” by addition to read as follows:

Our AMA:
(1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.
(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.
(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.

(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.
(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.
(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.
(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.
(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.
(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.
(11) opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or an opposing attorney to be present during, the independent medical examination, as a condition for the physician's medical opinions to be allowed in court. (Modify Current HOD Policy); and be it further

RESOLVED, That revised AMA Policy H-365.981, "Workers Compensation," be included in the AMA's *Guide to the Evaluation of Permanent Impairment*. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 03/20/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-19)

Introduced by: Minnesota

Subject: Addressing Existential Suffering in End-of-Life Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, The duty to relieve pain and suffering is central to the physician's role as healer; and

Whereas, Patients may experience both physical and existential suffering at the end-of-life; and

Whereas, Sedation to unconsciousness is an ethical practice to address refractory clinical symptoms, but is inappropriate to respond to existential suffering; and

Whereas, Existential suffering includes anxiety, isolation, loss of control, and other non-physical suffering that are serious conditions impacting patients' health; and

Whereas, Pharmacological or other clinical options short of sedation to unconsciousness may be appropriate to mitigate a patient's existential suffering; and

Whereas, Physicians have an ethical obligation to respect and consider the previously expressed wishes of a patient who has lost the ability to provide consent; and

Whereas, Existing AMA Council on Ethical and Judicial Affairs Opinion 5.6 addresses many of these issues in detail but does not expressly address two areas; and

Whereas, CEJA Opinion 5.6 states that existential suffering should be addressed through social, psychological, or spiritual support to the exclusion of other clinical options, even though there are treatments for existential suffering beyond social, psychological or spiritual support that are beneficial for patients; and

Whereas, CEJA Opinion 5.6 states that consent must be obtained from the patient or surrogate, but does not recognize or require consideration of a patient's previously expressed wishes in the case of surrogate decision making; therefore be it

RESOLVED, That our American Medical Association ask the Council on Judicial and Ethical affairs to review Ethical Opinion 5.6, "Sedation to Unconsciousness in End-of-Life Care," to address the following two issues: appropriate treatments beyond social, psychological or spiritual support to treat existential suffering, and the recognition of a patient's previously expressed wishes with end-of-life care. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/24/19

References:
1. N Kirk, T. W., & Mahon, M. M. (2010). National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients. Journal of pain and symptom management, 39(5), 914-923.
2. American Academy of Hospice and Palliative Medicine Statement on Palliative Sedation, http://aahpm.org/positions/palliative-sedation.

RELEVANT AMA POLICY

E-5.6 Sedation to Unconsciousness in End-of-Life Care

The duty to relieve pain and suffering is central to the physicians 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 patients 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.

AMA Principles of Medical Ethics: I,VII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-19)

Introduced by:	GLMA: Health Professionals Advancing LGBTQ Equality
Subject:	Conforming Sex and Gender Designation on Government IDs and Other Documents
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, The current US population of transgender adults is estimated to be about 0.6% of the US population, or about 1.4 million adults[1]; and

Whereas, A 2015 U.S. Transgender Survey conducted by the National Center for Transgender Equality (NCTE) found that 68% of transgender individuals live without a valid ID that matches their gender identity[2]; and

Whereas, The same survey noted that nearly one third (32%) of those who showed ID that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted[2]; and

Whereas, The cost of updating gender markers and procedural requirements (such as providing documentation of medical information) are among the main barriers preventing respondents from updating the gender on their IDs and records[2]; and

Whereas, One in four (25%) respondents reported problems regarding medical insurance in the past year related to being transgender, such as being denied coverage for care related to gender transition[2]; and

Whereas, Seventeen percent (17%) of respondents had an insurer refuse to change the name and/or gender in insurance records when requested and thirteen percent (13%) reported denial of coverage for services often considered to be gender-specific, including routine sexual or reproductive health screenings (such as Pap smears, prostate exams, and mammograms)[2]; and

Whereas, Government issued IDs include, but are not limited to, birth certificates, passports, driver's licenses, state identification cards, and other local, state, and federally issued identification; and

Whereas, At least ten states plus New York City and the District of Columbia currently issue updated sex designations on birth certificates and/or driver's licenses without requiring documentation from a medical provider: Arkansas,[3] California,[4] District of Columbia,[5] Idaho,[6] Massachusetts,[7] Minnesota,[8] Montana,[9] Nevada,[10] New Jersey,[11] New York City,[12] Oregon,[13] and Washington[14]; and

Whereas, At least ten states plus New York City and the District of Columbia offer birth certificates and/or driver's licenses with a gender-neutral option: California,[4] Colorado,[15] Connecticut,[16] District of Columbia,[5] Maine,[17] Minnesota,[18] Nevada,[10] New Jersey,[11] New York City,[12] Oregon,[19] Arkansas,[3] and Washington[14]; and

Whereas, Our AMA has strong policy advocating for removal of barriers to change the sex designation of an individual's birth certificate (H-65.967), but has outdated requirements for the change of sex designation and does not include mention of other government IDs within this policy; therefore be it

RESOLVED, That our American Medical Association modify HOD Policy H-65.967, "Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients," by addition and deletion to read as follows:

Conforming ~~Birth Certificate Policies to Current Medical Standards for Transgender Patients~~ Sex and Gender Designation on Government IDs and Other Documents (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~~ every individual's right to determine their gender identity and sex designation on government documents and other forms of government identification.

2. Our AMA supports policies that allow for a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional.

3. Our AMA supports policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification, which would be in addition to "male" and "female."

4. 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~~ supports efforts to ensure that the sex designation on an individual's government-issued documents and identification does not hinder access to medically appropriate care or other social services in accordance with that individual's needs. (Modify Existing Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1. The Williams Institute. https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf
2. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality
3. Arkansas Driver Services instructions, https://transequality.org/sites/default/files/docs/id/AR%20Drivers%20License%20gender%20change%20guidance.pdf
4. California Gender Recognition Act, SB 179, https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201720180SB179.
5. DC Gender Self-Designation Form, https://dmv.dc.gov/sites/default/files/dc/sites/dmv/publication/attachments/DC%20DMV%20Form%20Gender%20Self-Designation%20English.pdf.
6. Idaho Division off Public Health Instructions to Change the Indicator of Sex on an Idaho Birth Certificate to Reflect Gender Identity, https://healthandwelfare.idaho.gov/Portals/0/Health/Vital%20Records/GenderChangePacket_4-18.pdf.

7. MA Gender Designation Change Form, https://www.mass.gov/files/documents/2018/03/22/LIC108%20-%20Massachusetts%20Gender%20Designation%20Change%20Form_0.pdf.
8. Minnesota Driver and Vehicle Services Self-Designated Descriptors, https://dps.mn.gov/divisions/dvs/Pages/self-designated-descriptors.aspx
9. Montana Rule 37.8.311, Adoptions, Name Changes, and Gender Changes, http://www.mtrules.org/gateway/RuleNo.asp?RN=37.8.311
10. Nevada Administrative Code 440.030, https://www.leg.state.nv.us/Register/RegsReviewed/$R066-16A.pdf. Nevada Administrative Code 483-070, and see http://dmvnv.com/namechange.htm.
11. New Jersey Babs Siperstein Law, https://www.njleg.state.nj.us/2018/Bills/A2000/1718_R2.PDF.
12. New York City Health Code Article 207, https://www1.nyc.gov/assets/doh/downloads/pdf/notice/2018/noa-amend-article207-section207-05.pdf.
13. Oregon Health Authority House Bill 2673 Information Sheet, https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/CHANGEVITALRECORDS/Documents/OHA-2673.pdf; Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.
14. Washington WAC 246-490-075, Changing sex designation on a birth certificate, http://app.leg.wa.gov/WAC/default.aspx?cite=246-490-075.
15. Colorado Change of Sex Designation, https://www.colorado.gov/pacific/sites/default/files/DR2083.pdf.
16. Connecticut Department of Public Health Statement, https://www.cga.ct.gov/2019/PHdata/Tmy/2019SB-00388-R000225-Department%20of%20Public%20Health-TMY.PDF.
17. Maine Gender Designation Form, https://www1.maine.gov/sos/bmv/forms/GENDER%20DESIGNATION%20FORM.pdf.
18. MN Driver and Vehicle Services Self-Designated Descriptors, https://dps.mn.gov/divisions/dvs/Pages/self-designated-descriptors.aspx
19. Oregon Driver & Motor Vehicle Services instructions, https://www.oregon.gov/ODOT/DMV/Pages/driverid/chg_gender_designation.aspx.

RELEVANT AMA POLICY

Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.
Citation: Res. 003, A-17; Modified: Res. 005, I-18

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.
Citation: (Res. 4, A-13; Appended: BOT Rep. 26, A-14

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.
Citation: (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12

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.
Citation: (Res. 402, A-12

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer 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.
Citation: 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; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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.
Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

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 ones 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 ones gender identity.
Citation: Res. 010, A-17

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 prisoners 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.
Citation: BOT Rep. 24, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-19)

Introduced by: New York

Subject: Reimbursement for Care of Practice Partner Relatives

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Medicare has rules that exclude Medicare payments for items and services that, Medicare deems, would be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge; and

Whereas, Chapter 16 of Medicare guidelines (130 - Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household (Rev. 1, 10-01-03) A3-3161, HO-260.12, B3-2332) defines rules, these guidelines have not been revised since 2014; and

Whereas, The following degrees of relationship are included in definition of an immediate relative including husband and wife, natural or adoptive parents, child and sibling, stepparent, stepchild, stepbrother, stepsister, in-laws, grandparents, grandchildren and spouses of such grandparents and grandchildren; and

Whereas, Exclusion applies whether the provider is a sole proprietor who has an excluded relationship to the patient or a partnership in which even one of the partners is related to the patient; and

Whereas, Medicare makes the false assumption that a cardiologist seeing the father-in-law of an internist in his group would be compelled to provide cardiology services for free. This places the physician providing services in a difficult position where they provide services at a loss or must refuse to see the patient. This also puts the physicians, whose family member requires care, in an awkward predicament. They must either ask colleague to see their family member at a loss or tell the family member that it is not possible to be seen in their practice. Thus, this regulation strains physician-patient relationships and restricts access to trusted care; therefore be it

RESOLVED, That our American Medical Association support changes in the Medicare guidelines to allow a physician, who is a partner in the practice, to care for and receive appropriate reimbursement for immediate relatives of one of the other partners in their practice. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-19)

Introduced by: New York

Subject: Right for Gamete Preservation Therapies

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, A small but significant number of individuals have gender identities that differ from their genotypic and phenotypic gender; and

Whereas, An increasing number of these individuals will choose to undergo gender affirming treatment at some time during their reproductive lives; and

Whereas, Many transgender or non-binary individuals may desire to have children of their own just as cisgender individuals desire to have children of their own; and

Whereas, In order for a transgender or non-binary individual to have their own biological child, he or she generally must preserve their gametes prior to undergoing gender affirming medical and surgical therapies; therefore be it

RESOLVED, That fertility preservation services be officially recognized by our American Medical Association as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies (New HOD Policy); and be it further

RESOLVED, That our AMA officially support the right of transgender or non-binary individuals to seek gamete preservation therapies. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-19)

Introduced by: Wisconsin

Subject: Use of Person-Centered Language

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Communication is one of the foundational aspects of patient care that impacts patient satisfaction and builds rapport between a physician and patient;[1] and

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

Whereas, The use of person-first language may improve the doctor-patient relationship,[2] encourage a healthy relationship between researchers and the community,[3,4] and may reduce stigma associated with certain disease states;[5,6] and

Whereas, Multiple organizations including the federal Center for Disease Control and Prevention, American Psychological Association, and American Society of Addiction Medicine encourage person-first language;[7,8,9,10,11,12] and

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

Whereas, The use of person-centered language focuses on each person’s individual preferences rather than using generalizing terms for a group when referring to a disease state or disability, which seeks to maintain dignity and respect for all individuals;[13,14] and

Whereas, Certain groups - such as the deaf and the blind communities - speak against using person-first language because they identify their disability as a trait they possess instead of a pathologic process, and this issue is mitigated by using person-centered language;[15,16] and

Whereas, The Canadian Alzheimer's Society has developed specific guidelines for using person-centered language as to “not diminish the uniqueness and intrinsic value of each person and to allow a full range of thoughts, feeling and experiences to be communicated,” and to continue to build trusting relationships with these patients regardless of their condition;[13] and

Whereas, The AMA recommends the use of person-first language in the AMA Code of Style, and recently adopted policy regarding the use of person-first language for obesity (H-440.821) but failed to include other disease states; therefore be it

RESOLVED, That our American Medical Association encourage the use of person-centered language. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1. Mohammed, K *et al*. Creating a Patient-Centered Health Care Delivery System: A Systematic Review of Health Care Quality From the Patient Perspective. Amer. J of Med. 2016; 31(1): 12-21.
2. Schwartz, D *et al*. Seeing the Person, Not the Illness: Promoting Diabetes Medication Adherence Through Patient-Centered Collaboration. Clin. Diabetes. 2017 Jan; 35(1): 35-42.
3. Tai-Seale, M *et al*. The Language of Engagement: "Aha!" Moments from Engaging Patients and Community Partners in Two Pilot Projects of the Patient-Centered Outcomes Research Institute. Perm J. 2016 Spring; 20(2): 89-92.
4. Wynia M and Matiasek J. Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals. The Commonwealth Fund. 2006.
5. Puhl R, Peterson JL, Luedicke J. Motivating or stigmatizing? Public perceptions of weight-related language used by health providers. Int J Obes (Lond). 2013 Apr; 37(4): 612-9.
6. Noble AJ et al. 'Epileptic', 'epileptic person' or 'person with epilepsy'? Bringing quantitative and qualitative evidence on the views of UK patients and carers to the terminology debate. Epilepsy & Behavior 2017 Feb; 67: 20-27.
7. National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention. Disability Inclusion Strategies. 1 August 2017. Available at https://www.cdc.gov/ncbddd/disabilityandhealth/disability-strategies.html, Accessed 6 September 2017.
8. Dunn, DS and Andrews, EE. Person-first and identity-first language: Developing psychologists' cultural competence using disability language. American Psychologist 2015; 70(3): 255-264.
9. Botticelli MP and Koh HK. Changing the Language of Addiction. JAMA. 2016; 316(13): 1361-1362.
10. Obesity Action Coalition. Person-First Language for Obesity. 2017. Available at http://www.obesityaction.org/weight-bias-and-stigma/people-first-language-for-obesity, Accessed 19 September 2017.
11. National Alliance on Mental Illness. How to Be Inclusive and Welcoming. 2017. Available at https://www.nami.org/Get-Involved/NAMI-FaithNet/How-to-Be-Inclusive-and-Welcoming, Accessed 19 September 2017.
12. Psychiatric Rehabilitation Association. PRA Language Guidelines. 2002. Available at https://www.nccdp.org/resources/PRAlanguageguidelines.pdf, Accessed 6 September 2017.
13. Canadian Alzheimer's Society. Person-Centered Language. December 2012. Available at http://www.alzheimer.ca/~/media/Files/national/Culture-change/culture_person_centred_language_2012_e.pdf, Accessed 6 September 2017.
14. Kapitan, A. On "Person-First Language": It's Time To Actually Put The Person First. RadicalCopyEditor.com. 3 July 2017. Available at https://radicalcopyeditor.com/2017/07/03/person-centered-language/, Accessed 6 September 2017.
15. Collier, R. Person-first language: Noble intent but to what effect? CMAJ. 2012 Dec 11; 184(18): 1977-1978.
16. Mackelprang, R. Cultural Competence in Persons with Disabilities. In: Lum, Doman, Ed. Culturally Competent Practice. A framework for understanding diverse groups and justice issues. 4th ed. Belmont, CA: Brooks/Cole CENGAGE Learning; 2011: 437-465.

AMA Manual of Style > Section 2 Style > Subsection 11 Correct and Preferred Usage > 11.10 Inclusive Language > 11.10.4 Disabilities:

According to the Americans with Disabilities Act (http://www.usdoj.gov/crt/ada/), "a disability exists when an individual has any physical or psychological illness that 'substantially limits' a major life activity, such as walking, learning, breathing, working, or participating in community activities.'

Avoid labeling (and thus equating) people with their disabilities or diseases (eg, the blind, schizophrenics, epileptics). Instead, put the person first. Avoid describing persons as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from, stricken with, maimed). Avoid euphemistic descriptors such as physically challenged or special.

Avoid metaphors that may be inappropriate and insensitive (blind to the truth, deaf to the request). For similar reasons, some publications avoid the term double-blind when referring to a study's methodology.

Note: Some manuscripts use certain phrases many times, and changing, for example, "AIDS patients" to "persons with AIDS" at every occurrence may result in awkward and stilted text. In such cases, the adjectival form may be used.

RELEVANT AMA POLICY

Person-First Language for Obesity H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.
(Policy Timeline: Res. 402, A-17 Modified: Speakers Rep., I-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-19)

Introduced by: Resident and Fellow Section

Subject: Delegation of Informed Consent

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, The process of witnessed informed consent is a vital prerequisite to any invasive procedure or treatment, and constitutes a detailed back-and-forth discussion between the healthcare team and the patient regarding specific risks, benefits, indications and alternatives of that particular procedure or treatment; and

Whereas, Many physician groups and departments of physicians (particularly, specialists and subspecialists) frequently work as a well-organized "team" in order to better care for the patient and to improve the efficiency of patient care; and

Whereas, Allowing other qualified members of the health care team to participate in the informed care process may provide the patient with more information, more opportunities to ask questions and, ultimately, to be able to make an informed decision; and

Whereas, There are many situations when it is impractical to prohibit other competent members of the health care team (residents, nurses, physician assistants) to participate in the informed consent process; and

Whereas, The process of obtaining informed consent is a vital component in residency training to produce a competent independent physician; and

Whereas, A 2017 Pennsylvania Supreme Court ruling (*Shinal v. Toms*) mandated that a physician may not delegate to others his or her obligation to provide sufficient information to obtain a patient's informed consent[1]; and

Whereas, The Pennsylvania Supreme Court further stated in its judgment that the duty of informed consent is a non-delegable duty owed by the physician conducting the surgery or treatment; and

Whereas, This legal ruling may lead to a precedent with potential devastating and adverse unintended consequences to patient health by causing unnecessary and potentially harmful delays across the country; therefore be it

RESOLVED, That our American Medical Association in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient (Directive to Take Action); and be it further

RESOLVED, That our AMA study the implications of the *Shinal v. Toms* ruling and its potential effects on the informed consent process. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:
1. Shinal v. Toms, 2017 WL 2655387, at *17 (Pa. June 20, 2017).

RELEVANT AMA POLICY

2.1.1 Informed Consent
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 patients authorization or agreement to undergo a specific medical intervention. In seeking a patients informed consent (or the consent of the patients surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patients 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 patients 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 patients (or surrogates) 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 patients 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 Principles of Medical Ethics: I,II,V,VIII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Citation: Issued: 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.
Citation: (Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10

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.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-19)

Introduced by: Minority Affairs Section
GLMA: Health Professionals Advancing LGBTQ Equality

Subject: Preventing Anti-Transgender Violence

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William Reha, MD, MBA, Chair)

Whereas, A recent event has increased attention on violent crimes reported by the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) or gender non-conforming communities yet most media outlets have failed to accurately educate the public regarding the reality of the discrimination and physical dangers faced by members of the LGBTQ community,[1-7] especially Black transgender people and other transgender people of color; and

Whereas, Transgender individuals are people whose gender identity or gender expression differs from their sex assigned at birth;[8] and

Whereas, Transgender people who are People of Color, disabled, female identified, or a member of another oppressed group may struggle with discrimination on multiple levels;[9,10] and

Whereas, Violence against transgender people is often underreported due to transphobia and mistrust of law enforcement;[11] and

Whereas, In 2013, the Human Rights Campaign published its first report that tracked fatal violence against transgender people in the US and published its most recent report in 2018; and

Whereas, In the past six years of reporting by the Human Rights Campaign, 80% of all known transgender homicide victims were transgender women of color, 69% were Black transgender women; and

Whereas, Since 2013, at least 128 transgender women, transgender men, and non-binary people (people whose gender is not male or female) have been killed across 32 states and 87 cities in the US;[11] and

Whereas, In 2017, there were 29 homicides of transgender people in the US reported in the media, the highest number ever recorded, in addition to many more that were not publicly known; and

Whereas, In 2018, advocates tracked at least 226 deaths of transgender people in the US due to fatal violence, 82% of whom were transgender women of color and 73% of whom were Black transgender women;[11] and

Whereas, In the summer of 2018, violent attacks claimed the lives of nine Black transgender women in the span of only 10 weeks; and

Whereas, The Federal Bureau of Investigation reported a 17% increase in hate crime reports in 2017 compared to 2016 data, a rise for the third consecutive year;[12] and

Whereas, Of the more than 7,100 hate crimes reported in 2017, the Federal Bureau of Investigation concluded nearly three out of five were motivated by race and ethnicity; and

Whereas, Numerous studies have found that transgender people, especially transgender people of color, face high rates of sexual assault, intimate partner violence, and other non-fatal violence; and

Whereas, The largest survey to date of transgender individuals in the United States, the 2015 US Transgender Survey, found that 13% of all respondents reported being physically assaulted in the previous year; 47% reported ever experiencing sexual assault, including 10% in the previous year; and 35% reported ever experiencing physical violence from an intimate partner;[13] and

Whereas, The physical risks faced by transgender individuals can have long and short-term negative impacts on the physical and mental health of these individuals, survivors, their communities, and the nation as a whole; therefore be it

RESOLVED, That our American Medical Association partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience (Directive to Take Action); and be it further

RESOLVED, That our AMA issue a press release following the conclusion of the annual House of Delegates meeting with updates to be published in both scientific and mainstream publications regarding the prevalence of physical and mental health conditions and barriers faced by the LGBTQ community. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-19)

Introduced by: Minority Affairs Section

Subject: References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, The concept of protection against discrimination or harassment is not controversial, however, generally accepted, standard language for protected classes or groups does not exist among national organizations; and

Whereas, American Medical Association policy (and therefore Policy Finder) has multiple, inconsistent references with variable language regarding protection against discrimination or harassment against populations; therefore be it

RESOLVED, That our American Medical Association undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not (Directive to Take Action); and be it further

RESOLVED, That our AMA research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment (Directive to Take Action); and be it further

RESOLVED, That our AMA present the preliminary study results the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association produce a report within 18 months with study results and recommendations. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(A-19)

Introduced by: New Mexico

Subject: Covenants Not to Compete

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Covenants not to compete have been used to force physicians to leave communities if they leave hospital employment; and

Whereas, Recruiting and promoting new partners, building their referral bases, and purchasing necessary equipment is a significantly expensive undertaking; and

Whereas, Practices endure significant financial harm when a hospital can lure a partner away, and a requirement to pay liquidated damages when that happens mitigates the financial harm without requiring the partner to leave the community; and

Whereas, New Mexico passed a statue that prohibits covenants not to compete for employed physicians but allows for liquidated damages to be paid when a partner who is a part owner in a practice is lured away by a competing hospital system; and

Whereas, The New Mexico statute is a model that could be used by the AMA Council on Legislation as an example for other states; and

Whereas, The AMA Council on Ethical and Judicial Affairs opposes covenants not to compete in all circumstances; therefore be it

RESOLVED, That our American Medical Association consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician partner who is a part owner in practice is lured away by a competing hospital system (Directive to Take Action); and be it further

RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-19)

Introduced by: Michigan

Subject: Mature Minor Consent to Vaccinations

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Vaccines have been one of the most effective methods of infectious disease control in the past century, preventing 732,000 premature deaths in children born in the United States between 1994 and 2013; and

Whereas, One of the goals of Healthy People 2020 is to increase immunization rates, targeting a reduction in the incidence of 17 vaccine-preventable diseases in the United States; and

Whereas, There have been several recent well-publicized outbreaks of vaccine-preventable illnesses such as measles, mumps, and pertussis in the United States, including the 2018 Michigan measles outbreak; and

Whereas, The prevalence of unvaccinated pediatric patients is rising in the United States, and many children are unvaccinated due to parental distrust of vaccines; and

Whereas, Despite legislative efforts to regulate opt-out waivers for vaccinations, the Michigan immunization waiver rate remains higher than three percent for both kindergarten and eighth grade students, with greater than 70 percent of those waivers for philosophical rather than religious or medical reasons; and

Whereas, A 2018 study found that three of the nation's 14 metropolitan "hotspots" for non-medical exemption from vaccination are located in Michigan--Troy, Warren, and Detroit--demonstrating a high risk of vaccine-preventable disease outbreaks; and

Whereas, Declining vaccination rates increase the probability of outbreaks of vaccine-preventable diseases, and states with more opportunities for vaccination exemption have more measles outbreaks; and

Whereas, Unvaccinated adolescents report interest in receiving vaccines to prevent against common childhood illnesses; and

Whereas, Federal law does not require parental consent for vaccinations and many states, including Michigan, do not have comprehensive statutes surrounding vaccination policy; and

Whereas, Minors in the majority of states, including Michigan, are able to consent to some mental health services, sexually transmitted disease testing and treatment, birth control, and pregnancy related care; and

Whereas, Adolescents in 21 states do not require parental consent for treatment of reportable diseases, which include hepatitis B, measles, mumps, and pertussis; and

Whereas, The inability for minors to provide consent to vaccinations has been cited as a barrier to vaccination rates; and

Whereas, An American Academy of Pediatrics' article proposed minor consent to vaccination via the mature minor doctrine, a widely accepted legal concept allowing "certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a non-negligent manner;" and

Whereas, Vaccinations are safe, effective, low-risk, and necessary for a multi-faceted, comprehensive approach to public health and it is thus in the interest of the medical community and concerned citizens to promote access to vaccination; and

Whereas, Allowing mature minors an avenue to provide for their own personal health, when they have no medical contraindications to the vaccinations and are given the same comprehensive vaccine information as consenting adults, abides by the same ethical standards as other procedures allowed for in Michigan without parental consent; therefore be it

RESOLVED, That our American Medical Association amend the policy H-440.830, "Education and Public Awareness on Vaccine Safety and Efficacy," by addition and deletion as follows:

> Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; ~~and~~ (f) <u>supports state policies allowing adolescents to provide their own consent for vaccination and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g)</u> will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (f) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2.Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link

between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.
Citation: Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17

Achieving National Adolescent Immunization Goals H-440.901
Our AMA: (1) endorses the National Adolescent Vaccine Coverage Goals; and (2) endorses the collaboration of physicians, public health officials and legislators in each state to carry out strategies that ensure the National Adolescent Vaccine Coverage Goals are met.
Citation: Res. 411, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Childhood Immunizations H-60.969
1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.
Citation: (Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective

jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-19)

Introduced by: Medical Student Section

Subject: Improving Body Donation Regulation

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Body donation is essential to medical-surgical education, continuing education programs, clinical practice, and research, even as new virtual technology emerges[1-17]; 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 (FDA) and the Health Resources Service Administration (HRSA), respectively[25,26,27]; and

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

Whereas, As a result, body donation practices lack transparency and consistency, 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 results in lost tissues and incorrectly returned remains[30,33]; and

Whereas, Lack of regulation allows for market incentives to drive unethical body part acquisitions, requiring each individual institution, research team, and health care provider to set their own ethical bar[30,31,32]; and

Whereas, Lack of regulation 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 AMA supports federal oversight for processes involving tissue and organ donation to the medical profession through existing Policy (H-370.988); and

Whereas, The AMA Code of Ethics has established importance of removing potential financial incentives for organ donation (6.1.3), but there are no analogous policies for body donation; and

Whereas, Multiple institutional and professional organizational guidelines for ethical and productive body donation programs exist that could inform federal regulation[36]; therefore be it

RESOLVED, That our American Medical Association recognize the need for ethical, transparent, and consistent body donation regulations. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

E-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.

AMA Principles of Medical Ethics: I,III,V,VII,VIII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

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.

Citation: BOT Rep. E, I-89; Reaffirmed: Sunset Report, A-00; Modified and Appended, CSA Rep. 5, I-01; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

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.
Citation: (Res. 68, I-87; Reaffirmed: Sunset Report, I-97; Modified: CSA Rep. 5, I-01; Reaffirmed: CSAPH Rep. 1, A-11

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.
Citation: (CSA Rep. D, I-80; CLRPD Rep. B, I-90; Amended: Res. 504, I-99; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12

Organ Donation D-370.985
Our AMA will study potential models for increasing the United States organ donor pool.
Citation: Res. 1, A-14; Reaffirmed in lieu of Res. 5, I-14; Reaffirmed in lieu of: Res. 002, I-16

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.
Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, In 2017 it became policy that unaccompanied immigrant minors – children that enter the United States in family units and those that cross individually – 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 presented 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, and children in detainment are separated from their parents, and therefore do not have access to their own HIPAA rights[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[8-10]; and

Whereas, Undocumented children forcibly separated from parents at the US border have been shown to be at increased risk for post-traumatic stress disorder, anxiety, depression, aggression and suicidal ideation[11,12]; and

Whereas, Separating children from their parents during development has been linked with later risk of criminality and mental health issues such as bipolar disorder and schizophrenia[13]; 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 American Medical Association advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children (Directive to Take Action); 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 without patient consent. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA 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.

Citation: (Res. 8, I-14

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.
Citation: Res. 017, A-17

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.
Citation: Res. 018, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Professional medical associations serve physicians and 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, These positive contributions can be affected by financial conflicts of interest, especially in cases where for-profit companies' payments comprise a significant proportion of a professional medical association or a patient advocacy group's operating budget[2,5]; and

Whereas, A 2017 study of patient advocacy groups revealed that disclosure practices around funding sources and amounts, uses of funding, and corporate connections of management were inconsistent[4]; and

Whereas, The 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, indicating a significant conflict of interest[4]; and

Whereas, Patient advocacy groups motivated by their conflicts of interest may advocate for drugs to enter the marketplace prior to sufficient evidence or may advocate for insurance coverage of these drugs despite minimal or no benefits[2]; and

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

Whereas, Some professional medical associations set guidelines, and the National Academy of Medicine has recommended limiting authors of clinical guidelines to receive less than 50% of their funding from industry financial ties[7]; and

Whereas, Though the National Academy of Medicine 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, Disclosure engenders the public trust by providing transparency about financial relationships that a physician, physician organization, or professional medical organization has

with industry and enabling the public to weigh that influence on the organization's practices[5]; and

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

RESOLVED, That our American Medical Association support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

E-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 deliveredsuch as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the futurecan affect patientschoices, the patient-physician relationship, and physiciansrelationships with fellow health care professionals.
Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physiciansexercise 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 physiciansfinancial 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 physicianspprimary 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.
AMA Principles of Medical Ethics: I,II III,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

E-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 physicianstreatment recommendations.
AMA Principles of Medical Ethics: I,II,III,V,VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

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 biasingor 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 physicianstreatment 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.
AMA Principles of Medical Ethics: II
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

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.
BOT Rep. 20, A-99 Consolidated: CLRPD Rep. 3, I-01 Modified: CLRPD Rep. 1, A-03 Modified: CCB/CLRPD Rep. 3, A-12

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.
Citation: Res. 216, A-96; Reaffirmed: BOT Rep. 34, A-06; Reaffirmed: BOT Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, 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 US children age 13-17 years old and 700,000 of US adults identify as transgender or gender nonconforming[2]; and

Whereas, Compelled disclosure policies, including mandatory reporting laws, represent a growing effort by federal, state, and institutional agencies to increase transparency regarding abuses against vulnerable populations, but must be balanced against the constitutionality of compelled speech by showing there is a compelling reason for the speech to be compelled[3-5]; and

Whereas, Proposed Ohio House Bill 658 places explicit burden on educational and healthcare professionals to ascertain parental consent before pursuing subsequent therapeutic intervention for gender nonconforming minor patients[6]; and proposed constitutional amendment in Delaware would change discrimination protections to require disclosure of a student's gender identity/expression to parents before making accommodations in applicable educational programs[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 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--approximately forty percent 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, Sixty-one percent of LGBTQ+ youth report being open about their sexual orientation and/or gender identity at school[15]; and

Whereas, Twenty-six percent of LGBTQ+ youth do not want to disclose their sexual orientation and/or gender identity to teachers out of fear that those teachers might then tell their parents and 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 American Medical Association oppose mandated reporting of youth who question or express interest in exploring their gender identity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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 decision-making authority for that care, physicians should:
(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:
(i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;
(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;
(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.
(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.
(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.
(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).
(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.
(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.
(g) Consult experts when the patient's decision-making capacity is uncertain.
(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.
AMA Principles of Medical Ethics: IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

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 patients 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.

AMA Principles of Medical Ethics: I,IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended
Issued: 2016

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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.
Citation: Res. 05, A-16

Patient Privacy and Confidentiality H-315.983
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (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.
Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18

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.
Citation: Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16; Modified: Res. 903, I-17

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This

discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(A-19)

Introduced by: Medical Student Section

Subject: Sexual and Gender Minority Populations in Medical Research

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, In the United States, approximately eight 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 (SGM) as a health disparity population for research purposes[2]; and

Whereas, In 2015, the NIH established a Sexual and Gender Minority Research Office that provides funding earmarked for SGM-specific medical research[3,4]; and

Whereas, There continues to be a paucity of research regarding health care issues and integrated care interventions affecting lesbian, gay, bisexual, and transgender (LGBT)-identified youth and older adults[5-7]; 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, research has shown significant disparities between SGM groups and between those populations and the general public, such as modifiable risk factors for cardiovascular disease, prevalence and predictors of obesity, mental health and substance use disorders, sexually transmitted infections, and suicidal ideation and suicidality[9-16]; and

Whereas, The U.S. 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 multiple sources, including the National Academy of Medicine's 2011 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; 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 for research purposes, but our AMA is unclear in its position on collection of this data in the context of research studies; therefore be it

RESOLVED, That our American Medical Association amend policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition 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. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer 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.
Citation: 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; Res. 16, A-18; Reaffirmed: CSA

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.
Citation: Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17
PH Rep. 01, I-18

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.
Citation: (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.

Citation: CMS Rep. 5, I-08; Reaffirmed: Res. 203, I-09; Reaffirmation I-10; Reaffirmed: CMS Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(A-19)

Introduced by: Medical Student Section

Subject: National Guidelines for Guardianship

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, 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 combined 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 and 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 range 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 are commonly underfunded and understaffed which results in great difficulty enforcing the minimal regulations and protections currently 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, in addition to the lack of guardian registries in many states have created barriers to developing evidence-based regulatory and legislative solutions to abuses by guardians[10,13]; and

Whereas, The lack of standardization 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 policy does 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 American Medical Association collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: (CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13

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.
Citation: CSAPH Rep. 7, A-08; Reaffirmed: CSAPH Rep. 01, A-18

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.
Citation: Res. 431, A-08; Modified: CSAPH Rep. 01, A-18

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.
Citation: (CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09

E-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 patientswell-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) 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 normalfamilies, is a private matter best resolved without outside interference, or is caused by victimsown 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:
(i) inform patients about requirements to report;
(ii) obtain the patients informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patients 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.
AMA Principles of Medical Ethics: I,III
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-19)

Introduced by: Medical Student Section

Subject: Support for Requiring Investigations into Deaths of Children in Foster Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Around 670,000 children in the U.S will spend time in foster care in any given year, and the number of children in foster care has been increasing since 2012[1-4]; and

Whereas, Children in foster care are one of the most vulnerable populations, often suffering from a higher likelihood of early adverse childhood experiences and disproportionately affected by lack of appropriate housing, behavioral problems, and the disparities associated with minority populations[2,8-10];

Whereas, A series of highly-publicized episodes of abuse, neglect, and child deaths in the for-profit foster care system 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[3,5,6]; and

Whereas, The Senate Finance Committee report found that children in the foster care system die at an alarmingly high rate that is 42% higher than the national death rate for children with similar health conditions and risk factors, and 70% of these deaths were unexpected[3,7]; and

Whereas, These 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, In some cases children were placed in homes with individuals convicted of kidnapping and other serious crimes, with individuals who had substance abuse problems, and in the care of caretakers who had previously failed foster care placements;[3,5,6,7] and

Whereas, Investigations were conducted in only 15% of deaths with no subsequent action or autopsy performed in all other deaths[3,7]; and

Whereas, The report found that policies and procedures meant to monitor child welfare and providers' performance and outcomes were not consistently followed[3]; and

Whereas, AMA policy H-515.960 exhorts "physicians [to] 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 American Medical Association support legislation requiring investigations into the deaths of children in the foster care system that occur while the child is in the foster care system. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 05/09/19

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RELEVANT AMA 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.
Citation: Res. 907, I-17

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.
8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.
Citation: CSAPH Rep. 2, I-09; Appended: Res. 411, A-18

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.
Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

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.
Citation: (CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 019
(A-19)

Introduced by: Medical Student Section

Subject: Opposition to Requirements for Gender-Based Medical Treatments for Athletes

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, 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, The estimated incidence of DSD ranges 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 (IAAF) 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 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 commissioned by the IAAF published in the *British Journal of Sports Medicine* to investigate evidence of elevated testosterone levels and improved athletic performance[9]; and

Whereas, Independent researchers analyzed the data used for the IAAF study and found that the performance data used in the study's analysis was either anomalous or inaccurate 17% to 33% of the time, calling into question the study itself, with some experts calling for retraction[10,11]; and

Whereas, These new regulations have led the IAAF to request that female athletes with naturally high testosterone levels undergo medically unnecessary interventions to lower their testosterone levels to be allowed to participate in competitions, a request 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, 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 apply for an exemption to take steroids to increase testosterone levels, compared to female athletes with hyperandrogenism who can be 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 American Medical Association 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

References:

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RELEVANT AMA 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.
Citation: (CEJA Rep B, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

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.
Citation: (Res. 13, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11

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.
Citation: (Res. 89 part 2, A-72; Reaffirmed: CLRPD Rep. C, A-89; Modified by Res. 401, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

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.
Citation: (Res. 4, A-13; Appended: BOT Rep. 26, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(A-19)

Introduced by: New Mexico

Subject: Request to the AMA Council on Ethical and Judicial Affairs (CEJA) to Consider Specific Changes to the Code of Medical Ethics Opinion E-5.7, "Physician-Assisted Suicide", in Order to Remove Inherent Conflicts Within the Code, to Delete Pejorative, Stigmatizing Language, and to Adopt an Ethical Position of Engaged Neutrality

Referred to: Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Our American Medical Association House of Delegates at the 2018 Interim Meeting rejected the recommendation in CEJA Report 2-I-18 that the Code of Medical Ethics Opinion E-5.7 "Physician-Assisted Suicide" (PAS) not be amended, and therefore did not adopt CEJA Report 2-I-18; and

Whereas,

- The Code of Medical Ethics Opinion E-5.7 1 states, 'Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" – a characterization that clearly expresses the opinion that PAS is unethical; yet,
- The Code of Medical Ethics Opinion E-1.1.7 2 "Physician Exercise of Conscience" creates the clear understanding, not disputed by CEJA, that physicians participating in PAS are acting based on a thoughtful moral basis that is not outside the boundaries of ethical behavior; thereby,
- Creating an inherent contradiction within the Code of Medical Ethics: that physicians may ethically participate in something that is described as unethical; and

Whereas, It is important to recognize that ethical physicians can disagree, but that all perspectives be respected and none disparaged; and

Whereas, In addition to the inherent contradiction noted above, the decision that "the Code of Medical Ethics not be amended" is not consistent with the tenor of CEJA Report 2, and does not adequately address concerns about the implications of existing language in Opinion E-5.7; and

Whereas, The terms that stakeholders use to refer to the practice of physicians prescribing lethal medication to be self-administered by terminally ill patients reflect differing ethical perspectives, for the purposes of this resolution where existing language is not being cited, we have chosen to use "Physician-Assisted Dying" (PAD) as adopted by the American Academy of Hospice and Palliative Medicine[3] as being much more consistent with the goal of being respectful and non-disparaging; and

Whereas, CEJA Report 2 cites a specific example of irreconcilable differences in principled core beliefs, but neglects to note that CEJA in that instance had very wisely adopted a non-judgmental and non-stigmatizing approach that has served the profession well; and

Whereas, PAD is a decision made by a competent adult about how, when, where and with whom to end life in the face of an irreversible terminal illness where continued living is not an option, and therefore is not equivalent to or appropriately described as “suicide”, which can be most accurately defined as a decision by a person to take his or her own life rather than to continue living; and

Whereas, The American Association of Suicidology, in a treatise cited by CEJA[12], clearly states that, “Suicide and physician aid in dying are conceptually, medically, and legally different phenomena… the term ‘physician-assisted suicide’ in itself constitutes a critical reason why these distinct death categories are so often conflated, and should be deleted from use.”; and

Whereas, Eight states and a federal district currently authorize PAD as an end-of-life option, making PAD available to 21% of Americans, and sixteen additional states have introduced legislation to enact it; and

Whereas, As determined by numerous polls and surveys, the overwhelming majority of the public, consistently over 70% [4], supports PAD; and

Whereas, National surveys[5,6,7,8,11] of physicians demonstrate increasing support for PAD (from 46% in 2010 to 57% in 2016) and decreasing opposition to PAD (from 41% in 2010 to 29% in 2016); and

Whereas, Surveys of physicians conducted by the Colorado Medical Society [6], the Maryland State Medical Society [7], and the Massachusetts Medical Society[8] found majorities in support of PAD (56%, 54%, and 60% respectively); and

Whereas, There is no empirical evidence to substantiate the current description of PAD in Opinion E-5.7 as a form of abandonment “of a patient once it is determined that cure is impossible”, and in fact CEJA acknowledges that PAD is also considered to be “an expression of care and compassion”; and

Whereas, Claims in the Code of Medical Ethics Opinion 5-7 that characterize PAD as “difficult or impossible to control”, causing “more harm than good,” and posing “serious societal risks”, are unsubstantiated and speculative based on data reviews [9] cited in CEJA Report-2 that find conflicting interpretations but no definitive evidence to justify concerns for potential abuse; and

Whereas, It is widely acknowledged by patients, physicians and ethicists that suffering is not limited to physical pain, but equally includes emotional suffering due to loss of autonomy, and a loss of control over one’s destiny while an opportunity for such control clearly exists, as evidenced by overwhelming attestations on the part of patients who have chosen the option of PAD as having a sense of enormous relief and comfort, even by patients who in the end never take the cocktail they’ve been prescribed; and

Whereas, “Engaged Neutrality”[10] is a position that is neither “pro” nor “con”, but allows for the expression of diverse views while ensuring safeguards and appropriate standards, educating the public, care givers and physicians, and protecting physicians’ freedom to participate in or opt out of PAD according to their own personal values; therefore be it

RESOLVED, That our American Medical Association Council on Judicial and Ethical Affairs be strongly encouraged to remove from the Code of Medical Ethics Opinion E-5.7 "Physician-Assisted Suicide" judgmental, stigmatizing language that is not evidence based, is at odds with the conclusions of CEJA Report 2 in recognizing shared values of care, compassion, respect and dignity, and creates an ethical conflict with the Code of Medical Ethics Opinion E-1.1.7 "Physician Exercise of Conscience"; specifically by:

(a) Deleting all references to "suicide", including "Physician-assisted suicide" and replacing such language by referring to "Physician-assisted dying (PAD)";
(b) Deleting language that suggests that PAD is a form of doing harm and is therefore antithetical to the admonition to "do no harm", such as "assisted suicide would ultimately cause more harm than good";
(c) Deleting language that characterizes PAD as a choice by a patient "that death is preferable to life" and replacing that language with a description of PAD as giving a terminally ill patient the option of being in control of the manner of his or her death, without assigning a value judgment to that option;
(d) Deleting language that characterizes PAD as "fundamentally incompatible with the physician's role as healer", and instead recognizing that a physician who participates in PAD is doing so as an act of compassion and caring for patients who have no prospect of healing their fatal illness;
(e) Delete language that suggests that PAD is not compatible with "responding to the needs of patients at the end of life" or that PAD is "abandonment" (Directive to Take Action); and be it further

RESOLVED, In recognition of the fact that highly ethical physicians may have differing opinions on Physician Assisted Dying (PAD), but also in recognition of our respect for patient autonomy and the growing numbers of patients who wish to exercise choice over the manner of imminent death, that our American Medical Association's Council on Judicial and Ethical Affairs (CEJA) be strongly encouraged to modify Code of Medical Ethics Opinion E-5.7 "Physicians-Assisted Suicide" to follow the lead of a number of state and national medical societies by adopting the ethical position of "Engaged Neutrality", defined as neither in favor of nor or in opposition to PAD, while providing reassurance that our AMA will be a resource to lawmakers, physicians and the public to ensure compliance with standards of lawful medical practice, and to protect physicians' freedom to participate or not participate in PAD in accordance with their personal beliefs and our AMA's Opinion E-1.1.7 "Physician Exercise of Conscience". (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

[1] AMA Code of Medical Ethics, Opinion E-5.7, Physician-Assisted Suicide, https://tinyurl.com/y27hy743
[2] AMA Code of Medical Ethics, Opinion E-1.1.7, Physician Exercise of Conscience, https://tinyurl.com/y4odsvfm
[3] Statement on Physician-Assisted Dying, AAHPM Board of Directors, Jun 24, 2016 https://tinyurl.com/y3e4fka7
[4] 72% of Americans Support Medical Aid in Dying, Gallup Poll May 31, 2018 https://tinyurl.com/ycaon4zw
[5] Medscape Ethics Report 2016: Life, Death, and Pain, Dec 23, 2016 https://tinyurl.com/y3u63b8c
[6] Colorado Medical Society Member Survey, On Issues Surrounding Physician-Assisted Death, Feb 2016 https://tinyurl.com/y54b947y
[7] MedChi Survey on Physician Assisted Suicide/Aid in Dying, June-July 2016 https://tinyurl.com/y5dl4plq
[8] Massachusetts Medical Society (MMS) Survey on Medical Aid in Dying, August 2017 https://tinyurl.com/y34wqrrz
[9] Battin MP, van der Heide A, Ganzini L, et al, Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups, Journal of Medical Ethics 2007;33:591-597 https://tinyurl.com/yxharp6k
[10] Frye J, Youngner SJ. A Call for a Patient-Centered Response to Legalized Assisted Dying, Ann Intern Med. 2016;165:733–734. doi: 10.7326/M16-1319 https://tinyurl.com/yyzqmexo
[11] Assisted Death: Physician Support Continues to Grow, Medscape, Dec 2016 https://tinyurl.com/y3a6k2bl
[12] Statement of the American Association of Suicidology, Oct 2017: Suicide is not the same as "Physician Aid in Dying" https://tinyurl.com/yxholm6f

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-19)

Introduced by:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject:	Health, In All Its Dimensions, Is A Basic Human Right
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas In 1946, the World Health Organization (WHO) declared that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."[1] Health is defined by the WHO as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] The constitution added that governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures"[3] The international community furthered the right to health movement in the 1948 United Nations Declaration of Human Rights.[4]; and

Whereas, Presently, the United States is one of the only industrialized nations that doesn't provide universal access to health care;[5] and

Whereas, United States citizens have a longstanding pattern of poorer health, and are dying at younger ages than people in almost all other "peer" countries, including other high-income democracies in western Europe, as well as Canada, Australia, and Japan;[6] and

Whereas, The United States guarantees all citizens an education, access to fire and police services, a national postal service, protection by the military, a national park system, and many other federal- and state-funded services, but the country has not yet committed to ensuring that all of its citizens have health care in its many dimensions;[7] and

Whereas, Social determinants of health (the conditions in which people are born, grow, live, learn, work, and age that affect a wide range of health and quality-of-life outcomes and risks) are widely recognized as a primary approach to reducing health disparities and have become a public health focus at the global, national, state, and local levels;[8,9,10] and

Whereas, Numerous studies in recent decades have demonstrated the significant role nonmedical factors play in physical and mental health;[11]and

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[1] World Health Organization. Preamble to the Constitution of the World Health Organization. In: *Proceedings and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946*. New York, NY: World Health Organization; 1948:100. *Official Records of the World Health Organization*;
[2] Id.
[3] Constitution of the World Health Organization. https://www.who.int/governance/eb/who_constitution_en.pdf
[4] United Nations. The Universal Declaration of Human Rights. http://www.un.org/en/documents/udhr/
[5] Bauchner H. Health Care in the United States: A Right or a Privilege. JAMA. 2017;317(1):29. doi:10.1001/jama.2016.19687
[6] National Research Council (US); Institute of Medicine (US); Woolf SH, Aron L, editors. U.S. Health in International Perspective: Shorter Lives, Poorer Health. Washington (DC): National Academies Press (US); 2013. Available from: https://www.ncbi.nlm.nih.gov/books/NBK115854/ doi: 10.17226/13497
[7] JAMA. 2017;317(1):29. doi:10.1001/jama.2016.19687
[8] https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#c.
[9] http://www.who.int/social_determinants/thecommission/en/.
[10] https://www.cdc.gov/socialdeterminants/.
[11] http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve- patient-care-promote-health-equity-american.

Whereas, Food insecurity, for example, is associated with increased risk for diseases and conditions like diabetes, hypertension, and depression in adults, and with increased risk for impaired brain development, hospitalizations, iron-deficiency anemia, mental health, and behavioral disorders in children;[12,13,14,15,16] and

Whereas, Housing insecurity and homelessness are related to poorer physical health, including higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS and higher rates of medical hospitalizations; and

Whereas, Blue Cross Blue Shield of Massachusetts Foundation noted that there is strong evidence that increased investment in selected social services as well as various models of partnership between health care and social services can confer substantial health benefits and reduce health care costs for targeted populations;[17] and

Whereas, The social determinants of health play a key role in health outcomes and health disparities, and that addressing the social determinants of health for patients and communities is critical to the health of our patients, our communities, and a sustainable, effective health care system; and

Whereas, Planning the most effective strategy(s) to provide health care coverage in the United States is an evolving process, and will require careful evaluation, assessment, and modification; and

Whereas, The core principles to guide the envisioned future reforms and goals of health care have not been clearly stated; and

Whereas, Strategies to address future health care reforms and goals cannot be accomplished without stating and acknowledging the principles that will serve as the compass by which decisions will be made; and

Whereas, Physicians and medical societies should help define the principles upon which health care reforms and goals are structured and speak with a single voice and acknowledge that health is a basic right for every person in a just society, and not a privilege to be available and affordable only for a majority; and

Whereas, Physician members of the AMA rightfully focus on the provision of health care and its role in providing for the health of populations and a right to health care is only one aspect of a larger right to health;[18] and

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[12] Hunger and Health: The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being. Food Research and Action Center (FRAC). 2017.
[13] Hunger and Health: The Role of the Federal Child Nutrition Programs in Improving Health and Well-Being. Food Research and Action Center (FRAC). 2017.
[14] [8] Olsen CM. Nutrition and Health Outcomes Associated with Food Insecurity and Hunger. Journal of Nutrition. 1999;129(2):5215-5245.
[15] Cook JT, Frank DA, Berkowitz C, Black MM, Casey PH, Cutts DB, et al. Food Insecurity is Associated with Adverse Health Outcomes among Human Infants and Toddlers. Journal of Nutrition. 2004;134(6):1432-1438.
[16] Gundersen C, Ziliak JP. Food insecurity and health outcomes. Health Affairs. 2015;34(11):1830
[17] https://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity _ExecSumm_final.pdf.
[18] World Health Organization. Preamble to the Constitution of the World Health

Whereas, In addition to health care, a right to health encompasses a right to provision of social measures including sufficient food and drinking water, adequate housing and working conditions, satisfactory education; [19]and

Whereas, Spending on social measures arguably has a greater aggregate impact on population health than medical care; [20] and

Whereas, The United States currently gives limited attention to social programs and continues to outspend its peers on medical care;[21] and

Whereas, We as physicians share the professional responsibility to advocate for the health and well-being of our patients; and

Whereas, We as the AMA have consistently affirmed our common belief that comprehensive health care access should be available to all; and

Whereas, Principles to direct our AMA advocacy for patients should support a right to health, in all its dimensions (including addressing social determinants of health and universal access to timely, acceptable and affordable health care of appropriate quality care); and

Whereas, AMA policies on access to healthcare and its ongoing work and focus on social determinants of health and preventive care would benefit from core principles that support future advocacy and education; therefore be it

RESOLVED, That our American Medical Association acknowledge that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right (New HOD Policy); and be it further

RESOLVED, That the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 05/09/19

[19] United Nations. The Universal Declaration of Human Rights.
[20] K. Davis, K. Stremikis, C. Schoen, and D. Squires, Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014. https://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror-wall-2014-update-how-us-health-care-system
[21] Bradley EH, Elkins BR, Herrin J, Elbel B. Health and social service expenditures: associations with health outcomes. BMJ Qual Saf. 2011;20(10):826-831.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(A-19)

Introduced by:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject:	Opposition to Involuntary Civil Commitment for Substance Use Disorder
Referred to:	Reference Committee on Amendments to Constitution and Bylaws (William Reha, MD, MBA, Chair)

Whereas, Involuntary civil commitment is defined by law as the commitment of a person who is ill, incompetent, drug-addicted, or the like, without the consent of the person being committed; and

Whereas, In response to the opioid crisis, the scope of these laws has rapidly expanded, as the number of states with such laws went from 18 in 1991 to 38 jurisdictions in 2016[1]; and

Whereas, Existing data on both the short- and long-term outcomes following involuntary civil commitment for reasons related to substance-use disorder does not support its broad utilization[2]; and

Whereas, Data suggests that coercive treatment puts patients at higher risk of fatal overdose[3]; and

Whereas, The legal standards and procedures for involuntary civil commitment are very broad and allow for the presiding judge to overrule the clinical determination of the commitment's appropriateness; and

Whereas, Involuntary civil commitment of persons for reasons related to substance-use disorder has already been implicated in human rights abuses and suicides[4]; and

Whereas, Overdose data has shown that people who were involuntarily committed were more than twice as likely to experience a fatal overdose as those who completed voluntary treatment[5]; and

Whereas, Our AMA urges the formulation of a comprehensive national policy on drug abuse that should expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction (H-95.981, “Federal Drug Policy in the United States”); and

Whereas, Our AMA urges expanding the quantity and improving the quality of drug treatment programs (H-95.973, “Increased Funding for Drug Treatment”); and

Whereas, Our AMA policy is that health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients self-directed roles and responsibilities in maintaining health (Code of Medical Ethics Opinion 8.11 Health Promotion and Preventive Care)[6]; therefore be it

RESOLVED, That our American Medical Association oppose involuntary civil commitment without judicial involvement of persons for reasons solely related to substance-use disorder (New HOD Policy); and be it further

RESOLVED, That our AMA work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

[1]Involuntary Commitment For Individuals With A Substance Use Disorder Or Alcoholism, The National Alliance For Model State Drug Laws, 100 ½ E. Main Street, Manchester, Iowa 52057, © 2016 Research is current as of August 2016. Web/PDF http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf

[2] Nature and Utilization of Civil Commitment for Substance Abuse in the United States, J Am Acad Psychiatry Law 43:313–20, 2015 Web http://jaapl.org/content/43/3/313.long PDF http://jaapl.org/content/jaapl/43/3/313.full.pdf

[3] An Assessment of Opioid Related Deaths in Massachusetts (2013-2014) https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf

[4]Patients call Plymouth addiction center a mere jail - The Boston Globe

[5]https:l/www.mass.gov/service-detailslchapter-55-overdose-report

[6]https://www.ama-assn.org/delivering-care/ethics/health-promotion-and-preventive-care

Reference Committee A

CMS Report(s)

02 Covering the Uninsured Under the AMA Proposal for Reform
03 Medicare Coverage for Dental Services
04 Reclassification of Complex Rehabilitation Technology
05 The Impact of Pharmacy Benefit Managers on Patients and Physicians
06 Preventive Prostate Cancer Screening

Resolution(s)

101 Health Hazards of High Deductible Insurance
102 Use of HSAs for Direct Primary Care
103 Health System Improvement Standards
104 Adverse Impacts of Single Specialty Independent Practice Associations
105 Payment for Brand Medications When the Generic Medication is Recalled
106 Raising Medicare Rates for Physicians
107 Investigate Medicare Part D - Insurance Company Upcharge
108 Congressional Healthcare Proposals
109 Part A Medicare Payment to Physicians
110 Establishing Fair Medicare Payer Rates
111 Practice Overhead Expense and the Site-of-Service Differential
112 Health Care Fee Transparency
113 Ensuring Access to Statewide Commercial Health Plans
114 Ensuring Access to Nationwide Commercial Health Plans
115 Safety of Drugs Approved by Other Countries
116 Medicare for All
117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use
118 Pharmaceutical Pricing Transparency
119# Returning Liquid Oxygen to Fee Schedule Payment
120# Medicare Coverage of Hearing Aids
121# Maintenance Hemodialysis for Undocumented Persons
122# Reimbursement for Telemedicine Visits
123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
124# Increased Affordability and Access to Hearing Aids and Related Care
125# Mitigating the Negative Effects of High-Deductible Health Plans
126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies
127# Eliminating the CMS Observation Status

Contained in the Handbook Addendum

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Covering the Uninsured under the AMA Proposal for Reform
(Resolution 108-A-18)
(Reference Committee A)

EXECUTIVE SUMMARY

Expanding health insurance coverage and choice have been long-standing goals of the American Medical Association (AMA). The AMA proposal for health system reform is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage and choice to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and the Children's Health Insurance Program provide; and the preservation of employer-sponsored coverage to the extent the market demands it. The AMA proposal for reform recognizes that many individuals are generally satisfied with their coverage, but provides affordable coverage options to those who are uninsured or are having difficulties affording coverage options, including employer-sponsored, for which they are eligible.

The Council believes that our AMA proposal for reform, based on AMA policy, is still the right direction to pursue for covering the uninsured. In this environment, the Affordable Care Act (ACA) is the vehicle through which the AMA proposal for reform can be realized. That being said, the ACA is not broken, but it is imperfect. Instead of abandoning the ACA and threatening the stability of coverage for those individuals who are generally satisfied with their coverage, the Council believes that now is the time to invest not only in fixing the law, but improving it.

Improving the ACA targets providing coverage to the uninsured population, rather than upending the health insurance coverage of most Americans. In addition, focusing the efforts of our AMA on improving the ACA helps promote physician practice viability by maintaining variety in the potential payer mix for physician practices. As such, by putting forward the following new proposals to build upon and fix the ACA, as well as reaffirming existing policies adopted by the House of Delegates, the AMA proposal for reform has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Eliminate the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level;
- Increase the generosity of premium tax credits to improve premium affordability on ACA marketplaces and incentivize people to get covered; and
- Expand eligibility for and increase the size of cost-sharing reductions to help people with the cost-sharing obligations of the plan in which they enroll.

Importantly, the AMA proposal for reform provides a strong policy foundation to use in evaluating health reform proposals as they are introduced in the coming years, regardless of whether they are tied to the ACA. While the Council continues to believe that the AMA should not support single-payer proposals, the Council underscores that the AMA will continue to thoughtfully engage in discussions of health reform proposals, which will vary greatly in their structure and scope. Opposing single-payer proposals does not preclude that engagement, nor mean that the AMA should not evaluate health reform proposals that are introduced. Ultimately, our AMA, guided by policy, will continue forward in its efforts to advocate for coverage of the uninsured.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-19

Subject:	Covering the Uninsured under the AMA Proposal for Reform (Resolution 108-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 108, "Expanding AMA's Position on Healthcare Reform Options," which was sponsored by the Medical Student Section. Resolution 108-A-18 asked that our American Medical Association (AMA) remove references in AMA policy to opposing single-payer health care by rescinding Policies H-165.844 and H-165.985; amending Policy H-165.888 by deletion to remove "1(b) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed;" and amending Policy H-165.838 by deletion to remove "12. AMA policy is that creation of a new single-payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

This report provides background on health care coverage and costs in the US; summarizes potential approaches to cover the uninsured and achieve universal coverage; outlines factors to evaluate in proposals to expand coverage; and presents policy recommendations.

BACKGROUND

The health insurance coverage environment in the US for the nonelderly population heavily relies on the provision of employer-sponsored insurance, with nongroup coverage, Medicaid and other public programs covering smaller shares of the population. In 2017, 57 percent of the nonelderly population was covered by employer-sponsored health insurance coverage, with Medicaid and the Children's Health Insurance Program (CHIP) covering 22 percent, non-group plans covering eight percent, and other public plans covering three percent. Of concern, 27.4 million nonelderly individuals (10 percent) remained uninsured, an increase of 700,000 from 2016.[1]

The income demographic of the uninsured population is concentrated below 400 percent of the federal poverty level (FPL), with 82 percent of the uninsured with income below that threshold in 2017. Almost one-fifth of the uninsured population had incomes below the poverty line in 2017,[2] which in 2019 is $12,490 for an individual and $25,750 for a family of four.[3] Significantly, more than three-quarters of the nonelderly uninsured had at least one full-time worker in their family.[4]

At the same time, $3.5 trillion was spent on health care in the US in 2017, an increase of 3.9 percent from 2016 – amounting to $10,739 per person. Hospital care made up 33 percent of total health care spending, with spending on physician and clinical services amounting to 20 percent, and retail prescription drugs 10 percent. Overall, health care spending made up 17.9 percent of the gross domestic product (GDP) in 2017.[5]

Health care is financed by a variety of entities in the US, via dedicated taxes and/or general revenues, or by contributions made to health insurance premiums and out-of-pocket costs. In 2017, the federal government and households each accounted for 28 percent of health care spending. Health care spending by private businesses amounted to 20 percent of spending, with state and local spending following at 17 percent.[6]

MOVING FORWARD: APPROACHES TO COVER THE UNINSURED

The uptick in the uninsured rate, coupled with increasing pressures relating to health care costs, has caused momentum to build in support of action to cover the remaining uninsured. There have been two main approaches outlined in legislation and organizational policy proposals to date to improve the coverage climate in the US. First, legislation and organizational proposals have been put forward to build upon and fix the Affordable Care Act (ACA) to cover more people. As an alternative, other proposals have been introduced to use Medicare as the foundation to cover all US residents, or allow Medicare or Medicaid buy-ins.

The AMA Proposal for Reform

Expanding health insurance coverage and choice have been long-standing goals of the AMA. The approach to coverage as outlined under the AMA proposal for reform supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. Notably, the AMA health system reform proposal has been extensively deliberated by the House of Delegates over the past 20 years. Based principally on recommendations developed by the Council on Medical Service, beginning in 1998, the AMA proposal for covering the uninsured and expanding choice advocates for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits (Policies H-165.920 and H-165.865). Policy H-165.920 also supports and advocates a system where individually purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it. AMA policy also underscores that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health care coverage to otherwise uninsured groups (Policy H-290.974). AMA policy has long supported the creation of basic national standards of uniform eligibility for Medicaid (Policy H-290.997), and at the invitation of state medical societies, the AMA will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent FPL as authorized by the ACA (Policy D-290.979). Addressing a public option, Policy H-165.838 states that insurance coverage options offered in a health insurance exchange be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

Since the enactment of the ACA, the House of Delegates has been very proactive in and responsive to the evolving coverage environment to ensure that AMA policy is able to address how to best

cover the remaining uninsured. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent FPL (between 133 and 400 percent FPL in Medicaid expansion states) are being provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads them to face lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. At the time that this report was written, 36 states and the District of Columbia have adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.[7]

Significantly, the House of Delegates has adopted a multitude of policies that address coverage for the remaining uninsured in the ACA environment:

- *8.2 million individuals who are eligible for premium tax credits but remain uninsured:*[8] Policy H-165.824 supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits, and providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.

- *1.9 million individuals who are ineligible for premium tax credits due to income higher than 400 percent FPL:*[9] AMA policy supports expanding eligibility for premium tax credits up to 500 percent FPL, encouraging state innovation with reinsurance (H-165.824), and establishing a permanent federal reinsurance program (H-165.842).

- *3.8 million individuals who are ineligible for premium tax credits to purchase coverage on health insurance exchanges because they have an offer of "affordable" employer coverage:*[10] Policy H-165.828 supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," and supports lowering the threshold that determines whether an employee's premium contribution is "affordable," measured by comparing the employee's share of the premium to their income.

- *6.8 million individuals who are eligible for Medicaid or CHIP but remain uninsured:*[11] AMA policy supports efforts to expand coverage to uninsured children who are eligible for CHIP and Medicaid through improved and streamlined enrollment mechanisms and educational and outreach activities aimed at Medicaid-eligible and CHIP-eligible children. In addition, Policy H-290.961 opposes work requirements as a criterion for Medicaid eligibility.

- *2.5 million individuals with incomes below 100 percent FPL who fall into the "coverage gap" due to their state's decision not to expand Medicaid:*[12] Policy D-290.979 states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of FPL as authorized by the ACA.

- *Individuals who may choose not to get covered resulting from the elimination of the federal individual mandate penalty*: Policy H-165.824 encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. This policy builds upon Policy

H-165.848, which supports a requirement that individuals and families who can afford health insurance be required to obtain it, using the tax structure to achieve compliance. The policy advocates a requirement that those earning greater than 500 percent FPL obtain a minimum level of catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage subsidies would those earning less than 500 percent FPL be subject to the coverage requirement.

Building Upon and Improving the Affordable Care Act

Legislative and organizational proposals to build upon and fix the ACA, on both the federal and state levels, generally include one or more of the following provisions:

- Increasing the amount of and expanding eligibility for premium tax credits, including removing the "subsidy cliff;"
- Providing "enhanced" tax credits to young adults;
- Increasing amounts of cost-sharing reductions received by individuals who qualify for them;
- Extending eligibility for cost-sharing reductions beyond 250 percent FPL;
- Establishing a reinsurance program;
- Fixing the "family glitch;"
- Establishing a state individual mandate and/or auto-enrollment program; and
- Restricting the availability of short-term limited duration insurance (STLDI) plans and association health plans.

These proposals are generally targeted at the populations that remain uninsured under the law, as well as to address the reasons individuals are uninsured or underinsured in the current environment. For example, in 2017, 45 percent of uninsured nonelderly adults reported that they were uninsured because the cost was too high.[13] Increasing the amount of and expanding eligibility for premium tax credits and cost-sharing reductions addresses concerns with both high premiums and cost-sharing requirements.

Expanding Medicare or Medicaid to Cover the Uninsured

Legislation has also been introduced to use Medicare or Medicaid as vehicles to expand coverage. "Medicare-for-All" legislation has been introduced in the US House of Representatives and the Senate: S 1129, the Medicare for All Act of 2019 (Senator Bernie Sanders, I-VT), and HR 1384, the Medicare for All Act of 2019 (Representative Pramila Jayapal, D-WA). These bills call for the replacement of employer-sponsored insurance, individual market coverage, and most public programs, including Medicaid, Medicare and CHIP, with Medicare-for-All. The new Medicare-for-All program would have no premiums, and in general no cost-sharing, with the exception of S 1129 giving the Secretary of Health and Human Services (HHS) the authority to allow for cost-sharing for prescription drugs, up to $200 per year. The new Medicare-for-All program would cover all medically necessary services in outlined benefit categories, dental and vision services, with coverage of long-term services and supports varying based on the legislation. These proposals would establish a global budget for all health spending. A fee schedule would be established for physicians, guided by Medicare rates.[14,15,16]

As an alternative to the traditional Medicare-for-All proposals, "Medicare for America" legislation was expected to be reintroduced this session of Congress at the time that this report was written. Of note, there may be differences between the legislation introduced this Congress and that introduced last Congress. Unlike Medicare-for-All, Medicare for America as introduced during the 115th

Congress would allow large employers to continue providing health insurance to their employees, if they provide gold-level coverage (80 percent of benefits costs covered). Alternatively, they can direct their contributions toward paying for premiums for Medicare for America. If employers continue to offer health insurance to their employees, employees would have the ability to choose Medicare for America coverage instead of their employer coverage. There would also be premiums and cost-sharing under Medicare for America. Premiums would be on a sliding scale based on income, with individuals with incomes below 200 percent FPL having no premium, deductible or out-of-pocket costs. Premiums overall would be capped at no more than 9.69 percent of monthly income. Individuals and families with incomes between 200 and 600 percent FPL would be eligible to receive subsidies to lower their premium contributions, with current Medicare beneficiaries either paying the premium for which they are responsible under Medicare, or that of Medicare for America, whichever is less expensive. Out-of-pocket maximums would also be applied on a sliding scale based on income, with the caps being $3,500 for an individual and $5,000 for families. Provider payment under Medicare for America would be based largely on Medicare rates, with increases in payment for primary care, mental and behavioral health, and cognitive services, and the Secretary being given the authority to establish a rate schedule for services currently not paid for under Medicare. Participating providers under Medicare or Medicaid would be considered to be participating providers under Medicare for America. Notably, as a condition of participation in the program, providers would accept Medicare for America rates paid by employer-sponsored insurance plans and Medicare Advantage plans.[17,18]

Smaller scale proposals have also been introduced to allow older individuals to buy in to Medicare starting at age 50; establish a public option that would be offered through the exchanges based on Medicare; and allow individuals to buy in to Medicaid. Senator Debbie Stabenow (D-MI) has introduced S 470, the Medicare at 50 Act, and Representative Brian Higgins (D-NY) has introduced HR 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019, which would enable individuals to buy in to Medicare at age 50. Premiums would be based on estimating the average, annual per capita amount for benefits and administrative expenses that would be payable under Parts A, B, and D for the buy-in population. Notably, individuals enrolled in the buy-in would receive financial assistance similar to that which they would have received had they purchased a qualified health plan through the marketplace.[19,20]

Senator Brian Schatz (D-HI) and Representative Ben Ray Luján (D-NM) introduced S 489/HR 1277, the State Public Option Act. If enacted into law, the legislation which would give states the option to establish a Medicaid buy-in plan for residents regardless of income. Interestingly, for individuals ineligible for premium tax credits, their premiums cannot exceed 9.5 percent of household income. If these individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be capped as a percentage of their income. In terms of physician payment rates, the State Public Option Act would make permanent a payment increase to Medicare levels for a range of primary care providers.[21,22] In addition, several states are considering a Medicaid buy-in or public option, including New Mexico, Colorado, Minnesota, New Jersey, Connecticut, Washington and Maine.[23] Some state proposals would use Medicaid provider rates as the basis for payment levels, whereas others would use Medicare or other approaches.

Legislative proposals have also been put forward in Congress to establish a public option on the exchanges that rely on components of the Medicare program in program structure and to keep plan costs down. The public option, available to individuals and/or small employers eligible to purchase such coverage, would require Medicare participating providers to participate in the public option. Proposals differ in their approaches to provider opt-out provisions, and whether providers in Medicaid would also be required to participate in the public option. Such public option proposals would also base provider payment rates on Medicare, either extending Medicare payment rates or

using Medicare rates as a guide to establish payment levels. Individuals who qualify for premium tax credits and cost-sharing subsidies could use such subsidies to purchase the public option. All public option proposals would at a minimum cover essential health benefits as required under the ACA, with some proposals covering more benefits.

International Approaches to Universal Coverage

Countries that have achieved universal coverage show that there is no "one-size-fits-all" approach to covering the uninsured and health system financing. Health system financing varies from country to country. While some countries can fall into one overarching financing model, others may incorporate multiple financing models in their health systems. Such models include a single-payer system financed through taxes, and employer-sponsored insurance and coverage provided by nonprofit, private insurers.

Many countries finance their health systems generally through taxes, with the government serving as single-payer. For example, in Denmark, health care is financed predominantly through a national health tax, equal to eight percent of taxable income. In the United Kingdom, the majority of financing for the National Health Service comes from general taxation and a payroll tax. Partly as a result of the level of health care benefits provided by the government, countries with single-payer systems tend to have higher tax rates and social insurance contributions. Overall, taxes that fund social insurance programs are often higher in other developed countries than in the United States.

Other countries have employer-sponsored insurance and coverage provided through nonprofit, private insurers. For example, health insurance in Germany is mandatory for all citizens and permanent residents, and is primarily provided by competing "sickness funds," not-for-profit, nongovernmental health insurance funds. Sickness funds are financed by mandatory contributions imposed as a percentage of employees' gross wages up to a ceiling. High-income individuals can choose to opt out and instead purchase substitutive private coverage. Switzerland requires residents to purchase mandatory statutory health insurance, which is offered by competing nonprofit insurers. Direct financing for health care providers, predominantly for hospitals providing inpatient acute care, comes from tax-financed government budgets. Residents pay premiums for statutory health insurance coverage; premiums are redistributed among insurers by a central fund, adjusted for risk. In the Netherlands, all residents are required to purchase statutory health insurance from private insurers. Its statutory health insurance is financed through a combination of a nationally defined, income-related contribution; a government grant for insured individuals under the age of 18; and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula.[24]

In its analysis of international health systems, the Council noted that private insurance can play a supplementary and/or substitutive role to public health insurance options. Based on the country, premiums for private coverage can be paid by individuals and/or employers, unions or other organizations. Supplementary insurance, available in several countries, covers services that are excluded or not fully covered in the statutory plan, which could include prescription drug, dental and/or vision coverage. It can also build off the statutory coverage provided to improve coverage and can provide increased choice of or faster access to providers. For example, private health insurance in Australia and Norway offers more choice of providers, as well as expedited access to nonemergency care. Substitutive insurance is duplicative of coverage offered in the statutory plan, and could be available to populations not covered by or those who opt out of the statutory plan. In Germany, many young adults with higher incomes take advantage of substitutive private health insurance, because health insurers offer them coverage for a more extensive range of services, as well as lower premiums.[25]

The role of patient out-of-pocket payments in contributing to health care financing varies from country to country. In Canada, there is no patient cost-sharing for publicly insured physician, diagnostic and hospital services. In the United Kingdom, there is limited cost-sharing for publicly covered services. In countries where for many services patients have no cost-sharing, patients may have out-of-pocket responsibilities for outpatient prescription drugs, dental care and vision care. In many cases, vulnerable groups in these countries are either exempt from or face lower prescription drug copayments.[26]

Residents of Switzerland have similar types of cost-sharing exposures as privately insured individuals in the US. Insured adults are responsible for deductibles for statutory health insurance coverage, which can be lower, closer to $235, or higher, more than $1,900, depending on patient choice. After the deductible is met, individuals pay 10 percent coinsurance for all services, up to an annual maximum of approximately $550 for adults, with the cap for children being roughly half of that for adults. Low-income individuals are eligible for premium subsidies, and regional governments or municipalities cover the health insurance expenses of individuals receiving social assistance benefits or supplementary old age and disability benefits.[27]

Overall, several other countries, while requiring deductibles and/or copayments, also impose caps on cost-sharing, which limit patient out-of-pocket responsibilities. There are also exemptions from cost-sharing for vulnerable populations. For example, in Germany, there is an annual cap on cost sharing for adults equal to two percent of household income; the cap is equal to one percent of household income for chronically ill individuals. In Sweden, annual out-of-pocket payments for health care visits are capped below $200.[28]

Finally, approaches to paying providers vary, and are not wholly dependent on a country's health care financing model. Physicians can be salaried, or be paid via fee-for-service and capitation. Payments to physicians can also depend on whether patients have registered with and/or received a referral from their primary care physician. Physician fee schedules can be regulated or set by national, regional or local health authorities, negotiated between national medical societies/physician trade unions and the government, or negotiated/set by sickness funds or health plans. Physicians in some countries can also receive performance-based payments. Patient out-of-pocket payments contribute varying levels to physician payment, depending on cost-sharing responsibilities.

CONSIDERATIONS IN EVALUATING PROPOSALS TO EXPAND COVERAGE

Coverage Impacts

None of the legislative proposals to expand coverage highlighted in this report have been formally scored by the Congressional Budget Office to assess their impacts on coverage. That being said, proposals that would establish a single-payer system that would enroll all US residents into a single plan would be expected to lead to universal coverage. The coverage impacts of other proposals to expand coverage via a public plan available to all lawfully present individuals in the US would depend on whether individuals are able to opt out of the coverage, and what other provisions are included to maximize coverage rates. Some proposals would achieve universal coverage for legal residents, but not for undocumented individuals. Others, including public option proposals, would be expected to increase coverage, but at much lower rates.

The coverage impacts of proposals that aim to build upon and fix the ACA will depend on whether provisions to improve upon and/or expand premium tax credits and cost-sharing reductions; improve access to premium tax credits and cost-sharing reductions for those who find their

employer-sponsored coverage unaffordable; and/or establish a federal reinsurance program are coupled with mechanisms to maximize coverage rates, such as meaningful individual mandate penalties or an auto-enrollment mechanism. Also, additional states expanding their Medicaid programs would positively impact coverage rates, as 2.5 million of the nonelderly uninsured have incomes below 100 percent FPL and fall into the "coverage gap" due to their state's decision not to expand Medicaid.[29] Of note, certain policy options to improve the ACA have been evaluated to assess their potential impacts on overall coverage rates. For example, researchers from RAND Corporation modeled the impact of increasing the generosity of premium tax credits and extending eligibility for premium tax credits beyond 400 percent FPL, and concluded that implementing those policy options would increase the number of total insured by 2.4 million people in 2020. In addition, RAND modeled the impact of a generous reinsurance program, estimated to lead to an additional 2 million individuals having health insurance coverage in 2020.[30]

The Urban Institute also estimated the coverage impacts of reform proposals to build upon and fix the ACA, including:

- Reinstating the ACA's individual mandate penalties and cost-sharing reduction payments and prohibiting the expanded availability of STLDI plans;
- Expanding Medicaid eligibility in all remaining states, with full federal financing of the Medicaid expansion for all states; and
- Improving marketplace assistance, including the enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver level coverage; and establishing a permanent federal reinsurance program.

The Urban Institute assumed that 32.2 million nonelderly people would be uninsured in 2020. If these proposals to build upon and fix the ACA were enacted into law, the Urban Institute projected that number would drop to 21.1 million people in 2020 – a decrease of 11.1 million.[31]

Patient Choice of Health Plan

The ability of and degree to which patients would be able to choose their health plan would vary greatly under proposals put forth to cover the uninsured. Some Medicare-for-All proposals would not allow individuals with employer-sponsored coverage to keep their coverage; other proposals, including Medicare for America and proposals that build upon the ACA, would, to varying degrees. Depending on the proposal that builds upon Medicare to cover all US residents, patient choice of health plan would depend on whether the structure of the public plan is indeed a singular public plan in which everyone enrolls, or if it would follow a structure similar to Medicare Advantage. Under Medicare buy-in proposals, individuals starting at age 50 would have a choice between their existing mode of coverage and buying in to Medicare. Medicaid buy-in and other public option proposals are generally adding another plan to pick from on the marketplaces. The Council notes that if Medicaid buy-in and other public options are able to offer coverage at much lower premiums than existing marketplace plans, that could impact the size of premium tax credits available to individuals, which are pegged to the second lowest cost silver plan on the marketplace. If premium tax credit amounts are lower, individuals may have a choice of health plan, but may be able to afford fewer coverage options on the marketplaces.

Scope of Benefits

The scope of benefits under proposals introduced to cover the uninsured vary in terms of comprehensiveness of benefits and cost-sharing. Medicare-for-All proposals that have been introduced at the time that this report was written would cover medically necessary services in

outlined benefit categories, dental and vision services, and long-term services and supports. Generally, there would be no cost-sharing for these services, with the exception of S 1129**,** the Medicare for All Act of 2019, introduced by Senator Sanders, which would give the Secretary of HHS the authority to allow for cost-sharing for prescription drugs, up to $200 per year. Medicare for America would cover benefits determined to be medically necessary, including long-term services and supports for the elderly and individuals with disabilities, with cost-sharing responsibilities varying by income. Under the Medicare buy-in proposal for older individuals starting at age 50, such individuals would be entitled to the same benefits under Medicare Parts A, B and D as current Medicare beneficiaries. Public option proposals, including Medicaid buy-ins, generally follow the ACA's essential health benefits requirements, with cost-sharing dependent on income.

*Impacts on Patient Acces*s

Proposals to expand health insurance coverage can be expected to vary also in their impacts on patient access to care. Overall, increased demand for services would depend on how many individuals would become insured under the proposal. In addition, patient demand for services would vary based on the level of cost-sharing required under the proposal in question. For example, under traditional Medicare-for-All proposals, cost-sharing would generally be eliminated, which would be expected to lead to an increased utilization of medical services, as well as those services not typically covered under traditional health insurance (e.g. dental, vision, hearing). On the other hand, individuals use less care if cost-sharing is higher. As such, if patients were still responsible for a certain level of cost-sharing, the effect on demand for services would be expected to be more modest.

Provider supply and participation in any new public health insurance option can be expected to be impacted by the level at which providers are paid (e.g., Medicare or some variation thereof, Medicaid, new negotiated rates). For Medicare and Medicaid buy-in proposals as well as others that would create a public option, requiring provider participation could also impact whether providers continue to participate in traditional Medicare and/or Medicaid, potentially impacting current beneficiary access to care. In assessing the Medicare for All Act of 2017 as introduced by Senator Bernie Sanders, a working paper released by the Mercatus Center at George Mason University stated that "it is not precisely predictable how hospitals, physicians, and other health care providers would respond to a dramatic reduction in their reimbursements under M4A, well below their costs of care for all categories of patients combined."[32] In addition, RAND Corporation recently analyzed a single-payer plan for the state of New York, and an assumption incorporated into its modeling was that "providers reduce supply of services when payment levels decrease or financial risk increases."[33] Another RAND report assessing national health spending estimates under Medicare-for-All stated that "providers' willingness and ability to provide health care services including the additional care required by the newly insured and those benefiting from lower cost sharing would likely be limited."[34]

Of concern to the Council are those proposals that would greatly increase demand for services, while containing provisions expected to negatively impact provider supply. In detailing its methods for assessing the presidential campaign proposal of Senator Sanders in 2016, Urban Institute stated that "the Sanders plan would increase demand for health services by eliminating individuals' direct contributions to care (i.e., by eliminating deductibles, copayments, and coinsurance), but not all increased demand could be met because provider capacity would be insufficient."[35] The Mercatus Center study of the Medicare for All Act of 2017 stated that while some practices and facilities would be able to continue to operate, others would not, "thereby reducing the supply of health care services at the same time M4A sharply increases health care demand. It is impossible to say

precisely how much the confluence of these factors would reduce individuals' timely access to health care services, but some such access problems almost certainly must arise."[36] RAND's report on national health spending estimates under Medicare-for-All stated "[t]he extent and distribution of unmet care would depend on providers' payer mix under current law and their responses to Medicare-for-All payment levels. For example, some providers may elect to not participate in a Medicare-for-All plan (and instead enter in private contracts with individuals, an arrangement permitted in some single-payer bills), providers may alter when they retire, and potential medical students and trainees could change their career choices. As a result, some patients might experience longer wait times for care or face unmet needs."[37]

Concerns regarding wait times also echo data comparing health systems of different countries. For example, while 51 percent of patients in the United States were able to get an appointment the same or next day, that number falls to 49 percent in Sweden and 43 percent in Canada, and is 57 percent in the United Kingdom. Only six percent of patients in the US had a wait time of two months or longer to access a specialist, whereas wait times to see a specialist were significantly longer in countries with systems classified in the study as national health service and single-payer. Thirty-nine percent of patients in Canada had wait times of two-months or longer to see a specialist, with 19 percent of patients in the United Kingdom and Sweden facing such specialist wait times. Health systems in countries classified to be "insurance-based" (e.g. Germany, Switzerland, Netherlands, France) have more comparable wait times to the US.[38]

Other Impacts on Physician Practices

Health reform proposals that have been introduced have the potential to impact physicians and their practices in a multitude of ways, based on factors that include practice size and specialty; physician employment status; geography; and the payer mix of patients. As previously noted, transitioning the entire US population to a plan that pays Medicare rates, or has rates closely tied to that of Medicare, is expected to negatively impact practices that cannot cover their costs of care based on Medicare rates. Importantly, the Council notes innovation and practice enhancements can be undermined if practices were solely to rely on Medicare payment rates, therefore stifling delivery reform that promises to lower costs and improve care while maintaining access. Some Medicaid buy-in proposals raise similar concerns, especially those that use Medicaid payment rates in the buy-in program. On the other hand, proposals to build upon and fix the ACA would maintain the variety in the potential payer mix for physician practices.

The choices physicians currently have in their practice of medicine would be more limited under proposals that would enroll all US residents in a single public health insurance plan. That being said, it will be important to monitor if supplemental or substitutive private insurance would be allowed in such proposals, which would either replace the statutory coverage, or build off of the statutory coverage provided to improve coverage and provide increased choice of or faster access to providers. The Council notes that there may be an additional opportunity for physicians to participate in a parallel private market if it is allowed under such proposals.

Requirements for provider participation must be assessed in any proposal that would establish a public option or allow individuals to buy into Medicare or Medicaid. Such proposals assume physician participation in these plans if they participate in traditional Medicare and/or Medicaid. Under such proposals, if there is no provider opt-out provision, physicians would be expected to differ in their willingness to continue their participation in the existing traditional Medicare and Medicaid programs, as well as in their decisions on whether to accept new patients. Any proposal that ties physician participation in Medicare and/or Medicaid to a new public insurance option would also have the potential to significantly impact the payer mix of physician practices. The

Council notes that Policies H-285.989 and D-383.984 oppose "all products" clauses or linking a physician's participation in one insurance product to that physician's participation in any other insurance product.

Health reform proposals that drastically impact physician practice payer mix could also impact practice efficiency. While proposals that build upon the ACA would continue the practice of physicians interacting with a variety of health plans, transitioning all US residents into one public health insurance plan could mean that physicians only interact with one plan, with the same benefits package and payment rates, as well with one set of rules governing the use of utilization management practices.

Cost and Financing

The Council notes that none of the outlined legislative proposals to expand coverage have been formally scored by the Congressional Budget Office to assess their costs. That being said, think tanks and other entities have provided estimates of certain proposals. Medicare-for-All proposals that cover a comprehensive set of benefits with no cost-sharing are expected to incur the largest increases in federal spending. Recent analyses of Medicare-for-All proposals have been based on the Medicare for All Act of 2017 as introduced by Senator Sanders, his 2016 Medicare-for-All presidential campaign proposal, or a general Medicare-for-All proposal that would provide comprehensive health coverage, including long-term care benefits, with no-cost sharing. Of note, none of these analyses specifically measure the effects of S 1129, the Medicare for All Act of 2019, introduced by Senator Sanders in April of 2019. These analyses, published by the Urban Institute, the Mercatus Center at George Mason University, Kenneth Thorpe of Emory University and RAND Corporation, projected that Medicare-for-All proposals would require a large increase in federal spending. However, there are important differences among the analyses; as a result, they are not directly comparable. First, while Mercatus estimated the effects of the Medicare for All Act of 2017 as introduced, Urban Institute and Kenneth Thorpe evaluated Senator Sanders' 2016 presidential campaign proposal. As a result, the Mercatus Center assumed a four-year phase in of Medicare-for-All, but did not include an expansion in long-term services and supports – both differences between the 2017 version of the legislation and the campaign proposal. RAND, on the other hand, provided estimates of a more generic Medicare-for-All proposal. Of note, all of these studies made their cost projections over different time periods. The studies also did not have the same assumptions of the level at which providers would be paid under Medicare-for-All.[39,40]

The Mercatus Center estimated that the Medicare for All Act of 2017 would increase federal spending by approximately $32.6 trillion from 2022 to 2031, assuming a four-year phase-in period beginning in 2018.[41] The Urban Institute projected that federal spending under the 2016 presidential campaign proposal would increase by $32 trillion between 2017 and 2026.[42] The estimate of the campaign proposal put forth by Kenneth Thorpe was lower – closer to $25 trillion over the period from 2017 to 2026.[43] After the release of the Mercatus Center estimate, the Urban Institute noted that its estimates would differ if it were to standardize the assumptions between the two estimates. For example, Urban stated that if its estimate were over the same period as the Mercatus Center, and still included expansion of long-term services and supports, its estimate would be closer to $40 trillion.[44] RAND Corporation estimated that Medicare-for-All would increase federal health spending in 2019, rather than projecting a 10-year estimate, by 221 percent, from $1.09 trillion to approximately $3.5 trillion.[45]

All analyses estimating the cost of Medicare-for-All note that it would necessitate a complete change in how health care is financed in the US. Nearly all current national spending on health care by households, private businesses, and state and local governments would shift to the federal

government. How these entities fare after a transition to Medicare-for-All would ultimately depend on the pay-fors of the proposal. For example, in introducing the Medicare for All Act of 2019, Senator Sanders also released a white paper that laid out potential funding options, which included:

- Creating a 4 percent income-based premium paid by employees, exempting the first $29,000 in income for a family of four;
- Imposing a 7.5 percent income-based premium paid by employers, exempting the first $2 million in payroll to protect small businesses;
- Eliminating health tax expenditures;
- Making the federal income tax more progressive, including a marginal tax rate of up to 70 percent on those making above $10 million, taxing earned and unearned income at the same rates, and limiting tax deductions for filers in the top tax bracket;
- Making the estate tax more progressive, including a 77 percent top rate on an inheritance above $1 billion;
- Establishing a tax on extreme wealth;
- Closing the "Gingrich-Edwards Loophole;"
- Imposing a fee on large financial institutions; and
- Repealing corporate accounting gimmicks.[46]

Transitioning to the Medicare for America proposal, the Council notes that while the exact cost of the legislation is not yet known, it is expected to be significant, but cost less than the aforementioned Medicare-for-All proposals due to differences in plan premiums and cost-sharing requirements, and the role of employers. Of note, the sponsors of the bill put forward the following options to pay for the proposal as introduced during the 115th Congress:

- Sunsetting the Republican tax bill;
- Imposing a 5 percent surtax on adjusted gross income (including on capital gains) above $500,000;
- Increasing the Medicare payroll tax and the net investment income tax;
- Increasing the excise taxes on all tobacco products, beer, wine, liquor, and sugar-sweetened drinks; and
- Incentivizing states to make maintenance of effort payments equal to the amounts they currently spend on Medicaid and CHIP.[47]

The cost of proposals to build upon the ACA depends on the comprehensiveness of the proposal, and whether provisions are coupled with a mechanism to maximize coverage rates, such as an individual mandate or auto-enrollment system, as well as restrictions on short-term limited duration plans and association health plans. RAND Corporation estimated the impact on the federal deficit in 2020 of some potential proposals to improve coverage in the individual market under the ACA:

- Providing young adults with enhanced premium tax credits: $1.1 billion;
- Increasing the generosity of premium tax credits: $6.4 billion;
- Extending eligibility for premium tax credits beyond 400 percent FPL: $9.9 billion;
- Increasing and extending eligibility for premium tax credits: $18.8 billion; and
- Establishing a reinsurance program: Savings of $2.3 billion to $8.8 billion depending on generosity.[48]

The Urban Institute also estimated the impact of proposals to build upon and fix the ACA on federal spending on acute health care for the nonelderly in 2020:

- Reinstating the ACA's individual mandate penalties and cost-sharing reduction payments and prohibiting the expanded availability of STLDI plans: Savings of $11.4 billion;
- Expanding Medicaid eligibility in all remaining states, with full federal financing of the Medicaid expansion for all states (when added to the previous bullet): $68.1 billion; and
- Improving marketplace assistance, including enhancing the ACA's premium tax credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver level coverage; and establishing a permanent federal reinsurance program (added to the two previous bullets): $131 billion.[49]

The cost of public option proposals, as well as Medicare and Medicaid buy-ins, depends on several factors. First, the rate upon which provider payments are based will impact the cost, whether provider rates are tied to Medicare or a variation thereof, Medicaid, or another payment mechanism entirely. The cost of such proposals will also depend on whether they would be required to be financially self-sufficient and not depend on the traditional Medicare or Medicaid programs for parts of their financing. It will be paramount to assess the impact of any proposal that builds upon the Medicare program, or relies on Medicare program financing in part, on the solvency of the Medicare Trust Fund.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. On the whole, the AMA proposal for reform recognizes that many individuals are generally satisfied with their coverage, but provides affordable coverage options to those who are uninsured or are having difficulties affording coverage options, including employer-sponsored, for which they are eligible.

While the ACA has made great strides in covering the uninsured, the Council is concerned with the recent uptick in the uninsured rate, as well as future coverage impacts of zeroing out the federal individual mandate penalty, the expanded provision of STLDI, and other proposals put forward that could likely undermine the progress made to date. That being said, the ACA is not broken, but it is imperfect. Instead of abandoning the ACA and threatening the stability of coverage for those individuals who are generally satisfied with their coverage, the Council believes that now is the time to invest not only in fixing the law, but improving it. Improving the ACA appropriately targets providing coverage to the uninsured population, rather than upending the health insurance coverage of most Americans. Modifications to the law could also improve the coverage options for many who are underinsured and/or cite costs as a barrier to accessing the care they need. In addition, focusing the efforts of our AMA on improving the ACA helps promote physician practice viability by maintaining the variety in the potential payer mix for physician practices. Importantly, the Council is concerned about the cost of proposed Medicare-for-All proposals, and how the proposals' pay-fors would impact patients and physicians.

The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order to cover the uninsured, and is cognizant that, in this environment, the ACA is the vehicle through which the AMA proposal for reform can be realized. As such, by putting forward new proposals to build upon and fix the ACA, as well as reaffirming existing policies adopted by the House of Delegates, the AMA proposal for reform as follows has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to all individuals without an offer of "affordable" employer coverage.
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan.
- To help people currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income.
- The generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan.
- Young adults facing high premiums would be eligible for "enhanced" tax credits based on income.
- Eligibility for cost-sharing reductions would be increased to help more people with the cost-sharing obligations of the plan in which they enroll.
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impacts their ability to access and afford the care they need.
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums.
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding.
- To maximize coverage rates, the AMA would continue to support reinstating a federal individual mandate penalty, as well as state efforts to maximize coverage, including individual mandate penalties and auto-enrollment mechanisms.
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities.
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

Importantly, the Council stresses that our AMA proposal for reform provides a strong policy foundation to use in evaluating health reform proposals as they get introduced in the coming years, regardless of whether they are tied to the ACA. As such, the Council does not support the policy rescissions proposed in referred Resolution 108-A-18. While the Council continues to believe that AMA should not support single-payer proposals, there is the potential for other health reform proposals to be put forward in the future that could be consistent with AMA policy. The Council underscores that the AMA will continue to thoughtfully engage in discussions of health reform proposals, which will vary greatly in their structure and scope. Opposing single-payer proposals does not preclude that engagement, nor mean that the AMA will not evaluate health reform proposals that are introduced. Ultimately, our AMA, guided by policy, will continue forward in its efforts to advocate for coverage of the uninsured.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (New HOD Policy)

2. That our AMA support increasing the generosity of premium tax credits. (New HOD Policy)

3. That our AMA support expanding eligibility for cost-sharing reductions. (New HOD Policy)

4. That our AMA support increasing the size of cost-sharing reductions. (New HOD Policy)

5. That our AMA reaffirm Policy H-165.828, which supports legislation or regulation, whichever is relevant, to fix the Affordable Care Act (ACA's) "family glitch"; and capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-165.842, which supports the establishment of a permanent federal reinsurance program. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-165.824, which supports providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; and supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] FPL as authorized by the ACA. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support educational and outreach efforts targeted at those eligible for Medicaid and Children's Health Insurance Program, as well as improved and streamlined enrollment mechanisms for those programs. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health

plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-19

Subject: Medicare Coverage for Dental Services (Resolution 111-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 111, "Medicare Coverage for Dental Services," which was sponsored by the American College of Cardiology. Resolution 111 asked the American Medical Association (AMA) to (1) reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our health care team, and (2) promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

This report examines the unmet dental care needs of many Medicare beneficiaries, seniors' current options for obtaining dental health insurance and/or discounted care, the various challenges that would need to be overcome to create a Medicare benefit for dental services, and initiatives that are already underway to work towards better meeting the dental care needs of American seniors.

BACKGROUND

Medicare was created in 1965 as the federal health insurance program for people ages 65 and over, regardless of income or health status.[1] Medicare was later expanded to cover individuals under age 65 who are eligible for Social Security due to blindness or disability, or who have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare covers approximately 59 million people who meet one of the criteria for eligibility.[2] Notably, however, traditional Medicare does not include coverage for routine oral health care like checkups, cleanings, and x-rays, or restorative procedures (fillings, crowns, bridges, and root canals), tooth extractions, and dentures.[3] While some Medicare beneficiaries may be able to obtain dental coverage through other sources, the scope of dental benefits varies widely by geography and across plans. As a result, it is estimated that 70 percent of seniors lack or have limited dental insurance and fewer than half access dental care each year.[4]

Accordingly, Medicare beneficiaries have high out-of-pocket expenses when they do access dental care. For example, a 2016 analysis found that nearly one-fifth of the Medicare beneficiaries who received dental care paid more than $1,000 out-of-pocket.[5] For context, it has been reported that half of all Medicare beneficiaries live on annual incomes below $26,200, and one-quarter have incomes below $15,250.[6] The lack of dental coverage and high out-of-pocket costs can lead to patients delaying or forgoing dental care due to cost, as well as higher expenditures for medical and emergency care associated with untreated dental problems. However, while cost is often cited as a top reason for patients not going to the dentist, it is only one of many challenges senior citizens

face as they seek dental care. Additional significant factors include: fear of the dentist, inconvenient appointment times or locations, dental health professional shortages, transportation challenges, and health literacy issues.[7]

At the same time, Medicare beneficiaries may have medical conditions and medications that worsen their oral health, or oral health issues that exacerbate or complicate treatment of their other medical conditions. Tooth decay and other oral diseases, when untreated, can cause pain, chronic and acute infection, tooth fractures and loss, compromised oral function, and impaired quality of life. Dental problems can make it difficult to eat, leading to poor nutrition, weight loss or gain, and exacerbation of chronic conditions like hypertension, diabetes, and hyperlipidemia – conditions which are common later in life. In addition, oral infections can be especially dangerous for older adults with weakened immune systems.[8] Recognizing that dental care is integral to overall well-being, many within the medical, dental, and patient advocacy communities have suggested that Medicare begin including dental care as a standard benefit. However, there is considerable agreement that adding the benefit would be very expensive and politically challenging.

CURRENT OPTIONS FOR DENTAL COVERAGE FOR SENIORS

It is important to recognize that the scope of dental coverage and affordability of dental care is an issue for people of all ages. The scope of covered benefits, cost-sharing rules, and annual dollar limitations that apply to private dental insurance plans can lead patients of all ages to face high out-of-pocket costs for dental treatment, and this issue extends to Medicare beneficiaries.[9] Medicare coverage policy for dental care is not completely clear, and the Medicare program is reviewing its authority to provide additional services. Currently, dental-related Medicare coverage includes:

- Dental services that are an integral part of a covered procedure;
- Extractions performed in preparation for radiation treatment for cancers involving the jaw;
- Oral examinations (but not treatment) preceding kidney transplants or heart valve replacements; and
- Hospital care resulting from complications of a dental procedure (but excluding the cost of the dental care).[10]

While traditional Medicare does not cover routine oral health care or restorative procedures, seniors have some options for obtaining some level of dental insurance coverage and/or discounted dental care. Medicare Advantage (MA) plans have been an option for seniors, as an alternative to enrolling in traditional Medicare, since the 1970s.[11] Virtually all Medicare beneficiaries have access to at least one MA plan in their area, and in 2018, the average Medicare beneficiary could choose among 21 MA plans offered by six insurers. MA plans provide all Medicare-covered services (except hospice), and they typically provide additional benefits, including dental care. For example, in 2018, approximately two-thirds of MA beneficiaries were enrolled in plans that offer some dental coverage. Beginning in 2019, MA plans will be able to provide targeted services for beneficiaries with chronic conditions. MA continues to be an increasingly popular option among Medicare beneficiaries: enrollment in MA plans has more than tripled, with 6 million beneficiaries in 2005 and 20 million reported in a 2018 study. Its popularity is expected to continue to grow – in 2018, 34 percent of the Medicare population was enrolled in MA, and that figure is projected to rise to 42 percent by 2028. However, as with insurance for other populations, some MA plans charge an additional premium for dental benefits, cost-sharing requirements vary by plan and geography, and dollar limitations on coverage commonly apply.[12]

In addition to MA plans being available, some Medicare beneficiaries receive dental coverage via Medicaid, employer-sponsored retiree health plans, or individually purchased dental plans.[13]

Again, however, the scope of dental benefits varies widely. Seniors must meet qualification criteria for Medicaid benefits, and not all states' Medicaid programs offer dental benefits.[14] Seniors (like other individuals) with employer-provided dental coverage must purchase their dental health plan separately from their medical insurance. Additionally, seniors can choose to purchase individual dental insurance plans through a variety of commercial insurance companies, or they can buy into a program that provides access to discounted dental care. However, given that these plans and programs carry sometimes significant monthly costs and can impose restrictive annual maximums on coverage (for example, a $1,000 annual maximum in some dental PPOs[15]), seniors must carefully consider whether such options are cost effective for them. Finally, some dental offices offer their own in-office dental plan (also known as a "dental membership savings plan" or "direct primary care agreement").[16] Patients participating in such plans pay their dentist/dental office a fixed amount per month or per year, and then they generally receive preventive services at no charge and discounts on other procedures.

CHALLENGES TO CREATING A NEW MEDICARE DENTAL BENEFIT

While it is clear that seniors need better access to affordable dental care, it is not clear how to provide that needed service via a new Medicare standard dental benefit. First, as a general matter, the Medicare program is already struggling under profoundly challenging finances. The 2018 Medicare Trustees Report (the 2018 Report) explains that Medicare Part B and Part D, which together comprise the Supplementary Medical Insurance Trust Fund (SMI), will continue to place a significant burden on the finances of taxpayers and Medicare beneficiaries. SMI costs are projected to demand an increasing proportion of beneficiaries' incomes, and SMI costs are projected to increase significantly as a share of GDP over the next 75 years, from 2.1 percent to 4.0 percent.[17] Yet, adding a comprehensive benefit for dental coverage to Medicare Part B has been estimated to cost approximately $32.3 billion.[18] Policymakers considering a new dental benefit would have to weigh significant competing demands to reduce growth in Medicare spending for currently covered benefits while also addressing the need for a very expensive additional benefit. It is also important to avoid jeopardizing funding for current Medicare benefits. This complicated policy decision must be made in the context of the broader solvency issues facing the Medicare program. The 2018 Report indicated that the Hospital Insurance Trust Fund (HI) component of Medicare has an estimated depletion date of 2026, which is three years earlier than in last year's report.[19] As in past years, the Trustees determined that the fund is not adequately financed over the next 10 years. In fact, the Trustees project deficits in all future years until the trust fund becomes depleted in 2026.

Second, creating a new Medicare benefit for dental care would require legislative and regulatory action. A statutory exclusion in Section 1862(a)(12) of the Social Security Act prevents inclusion of dental benefits in Medicare.[20] Congress would need to act to remove that exclusion, and additional statutory changes, such as establishing a scope of services and structuring provider payment, would be required to ensure a smooth integration of dental benefits into Medicare. Additionally, the Centers for Medicare & Medicaid Services (CMS) would need authority to promulgate new regulations to implement and administer Medicare dental health benefits.

Even if a new Medicare dental benefit were enacted, it is not clear that dentists would be sufficiently interested in participating to provide good access to dental care for Medicare patients. With 40 percent of national health expenditures for dental care being paid by patients out-of-pocket, dentists have been less reliant on third-party payer financial support for their practices than have physicians.[21] Additionally, dental fee-for-service models typically include unique costs such as dental laboratory material and supplies within the fee for a given procedure, and comprehensive dental practices often house significant equipment that contributes to large overhead costs. The

extent to which a newly created Medicare dental benefit covers these costs is likely to influence dental practices' decisions about whether to participate in a Medicare dental benefit.

PROPOSALS FOR IMPROVING ACCESS TO DENTAL CARE FOR SENIORS

A variety of policy options could be considered to expand access to dental care for Medicare beneficiaries. As "America's leading oral health advocate," the American Dental Association (ADA) is deeply committed to advocating for public policies "affecting the practice of dentistry and the oral health of the American public."[22] The ADA recognizes senior citizens' compelling need for dental care and continues to study methods for improving seniors' access to dental care, to explore the possibility of a Medicare dental benefit, and to advocate on behalf of the dental community and its patients. The ADA recently contributed to a multi-disciplinary collaboration that included representatives from the Center for Medicare Advocacy, Oral Health America, Families USA, Justice in Aging, and the Santa Fe Group and resulted in a white paper analyzing a potential oral health benefit in Medicare Part B. While the resulting white paper advocates for inclusion of an oral health benefit in Medicare Part B, the ADA has not reached that conclusion. Instead, the ADA's position has been one of thoughtful engagement, without endorsing a new Medicare dental care benefit. The ADA contributed data to the white paper, explaining that, "The ADA Board of Trustees determined that it was critical for the ADA to educate this coalition to ensure that the dentist perspective on this national health policy issue is represented and understood."[23] Critically, however, the ADA stated that "the Association's input does not constitute endorsement of inclusion of a dental benefit under Medicare at this time."[24] Instead, the ADA explained, "Ultimately, success depends on establishing a sustainable program that will actually increase oral health for seniors."[25] As of July 2018, the ADA's Council on Dental Benefit Programs has been "studying this issue [of a Medicare dental benefit] in order to make an informed recommendation for the profession."[26] More recently, when the ADA House of Delegates met in October 2018, it adopted policy that "calls for the ADA president to appoint an ad hoc committee to review and update existing policy. . . and to identify an implementation plan and timeline to address elder care including Medicare."[27] AMA staff communications with ADA staff indicate that the ADA is carefully studying the issue of senior oral health and Medicare coverage for dental services, and it plans to issue further guidance in the near future, potentially as soon as late 2019.

In addition to the proposal to add a dental benefit to Medicare Part B, others have proposed an optional supplementary Medicare benefit to provide coverage for dental, vision, and hearing services, similar to the Medicare Part D benefit. The optional benefit package would be mostly funded through premiums (with income-based subsidies that follow the design of the Part D subsidy potentially available). At the same time, the study authors acknowledge that calculating the cost of such a benefit package is challenging and dependent upon many assumptions, and they describe their policy option as a starting point for discussion and more extensive modeling.[28] Other policy options include the contention by some advocates that CMS has the authority to cover oral health care when it is medically necessary for the treatment of Medicare-covered diseases, illnesses, and injuries, and CMS is reviewing this question.[29]

Each of these policy options raises questions about budget, scope of coverage, cost-sharing, provider payment, and administration. To inform the policy debate, further studies of possible Medicare benefit plan design, impacts on clinical outcomes, and cost effectiveness are needed. For example, researchers could study outcomes and impacts reported from MA plans offering varying degrees of dental coverage to inform optimal benefit design. Additionally, clinical and comparative effectiveness research from the National Institute of Dental and Craniofacial Research (NIDCR) could inform future analyses.

As the specific debate surrounding a Medicare dental benefit continues to unfold, the ADA is also engaged in broader efforts to examine barriers to dental care and expand access. As part of a series on Access to Oral Health, the ADA issued a report on the role of finance in breaking down barriers to oral health for all Americans. The ADA emphasized that "adequate funding should be made available through both public and private financing mechanisms. Financial barriers to care must be removed or lessened to increase the utilization of dental services."[30] However, the ADA explained that "increased funding alone cannot 'fix' a dental financing system that is rife with inefficiencies and shifting policies. . . Funding alone will not guarantee other needed improvements in the system."[31] Since 2014, the ADA has led a community-based, grassroots movement called Action for Dental Health. Action for Dental Health aims to provide care for people who suffer from untreated dental disease, to strengthen and expand the public/private safety net, and to bring disease prevention and education into communities. This movement advocates for increased dental health protections under Medicaid, providing dental care for seniors in nursing homes with funding through Medicaid, training other health professionals to provide basic dental health education and recognize conditions that need to be referred to a dentist, and providing free dental care to underserved populations.[32] The Action for Dental Health movement recently won a significant victory with the enactment of the Action for Dental Health Act (the Act) which aims to improve access to oral health care for underserved Americans.[33] Specifically relevant to the issue of senior dental care, the Act supports the development of models for the provision of dental services (such as dental homes) for children and adults including the elderly, blind, individuals with disabilities, and individuals living in long-term care facilities. The Act will also support initiatives to reduce the use of emergency departments by individuals seeking dental services that would be more appropriately provided in a dental primary care setting.[34]

AMA POLICY

AMA policy emphasizes the important role of oral health in overall patient care. Policy D-160.925 recognizes the importance of managing oral health and access to dental care as a part of optimal patient care. The policy also states that the AMA will explore opportunities for collaboration with the ADA on a comprehensive strategy for improving oral health care and education for clinicians. Additional policy supports providing coverage for dental care for medical residents and fellows in training (Policies H-295.873 and H-310.912) and for individuals with developmental disabilities (Policy H-90.968).

Policy regarding insurance coverage for hearing aids is also instructive, as hearing aids constitute another category of care that is not covered by traditional Medicare, but that is critical to patient well-being. Policy H-185.929 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. The policy also supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit.

However, Policy H-185.964 opposes new health benefit mandates unrelated to patient protections that jeopardize coverage to currently insured populations. Additionally, under Policy H-165.856, the AMA supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Extensive AMA policy emphasizes the importance of collaboration with health care community stakeholders and national medical specialty societies. Several policies support continued collaboration with national medical specialty societies, interest groups, and other stakeholders to develop clinical guidelines for preventive services; encourage coverage for evidence-based recommendations regarding preventive services, especially for populations at high risk for a given

condition; and promote to the public and the profession the value of Medicare-covered preventive services (Policies D-330.935, D-330.967, H-425.987, and H-425.988). Similarly, Policy D-185.979 encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

DISCUSSION

The Council commends the sponsors of referred Resolution 111-A-18 for highlighting the inextricable link between oral health and overall health and well-being and the dental care needs of Medicare beneficiaries. In light of the AMA's policy commitment to collaborating with the ADA, the critical importance of the dental profession's perspective on the issue of creating a Medicare benefit for dental care, and the currently evolving research on this issue, the Council believes that the AMA should continue to explore opportunities to work with the ADA to improve access to dental care for Medicare beneficiaries. As part of this collaboration, the AMA should continue to monitor and evaluate the ADA's research and policy recommendations regarding a Medicare benefit for dental care and the broader challenge of meeting the oral health care needs of America's senior citizens. In addition, the Council believes that the AMA should support initiatives to expand health services research regarding expanding affordable access to dental care for Medicare beneficiaries. This research could include studies of the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs for improving health and preventing disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. Finally, to underscore the importance of the goals articulated through Resolution 111-A-18 and the AMA's commitment to working with the ADA to achieve these goals, the Council recommends reaffirming Policy D-160.925, which recognizes the importance of managing oral health, access to dental care as a part of optimal patient care, and collaboration with the ADA.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-160.925, which recognizes the importance of managing oral health, access to dental care as a part of optimal patient care, and collaboration with the American Dental Association (ADA). (Reaffirm HOD Policy)

2. That our AMA support continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. (New HOD Policy)

3. That our AMA support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (New HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policy Recommended for Reaffirmation

Policy, D-160.925 Importance of Oral Health in Patient Care
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. (Res. 911, I-16)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-19

Subject: Reclassification of Complex Rehabilitation Technology (Resolution 117-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 117-A-18, "Supporting Reclassification of Complex Rehabilitation Technology (CRT)," which was introduced by the Texas Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 117-A-18 asked that our American Medical Association (AMA) "advocate for the Centers for Medicare & Medicaid Services (CMS) to reclassify CRT as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs."

In this report, the Council explains complex rehabilitation technology, discusses legislation that has impacted funding for CRT, summarizes competitive bidding in this context, and highlights relevant AMA policy. The Council concurs with the intent of Resolution 117-A-18, and recommends minimal modifications to avoid potential unintended consequences of the reclassification.

BACKGROUND

Resolution 117-A-18 identifies challenges with the current classification of CRT within the broader category of durable medical equipment (DME) under Medicare's payment rules. The resolution explains that the DME category used by CMS does not distinguish technological differences between CRT and other DME. CRT is often required for optimal ongoing mobility at home as well as in daily living activities for individuals with debilitating chronic illnesses. The resolution also notes that long-term care facilities may not provide medically necessary CRT due to the cost or lack of experience with CRT configuration.

CRT can include specialized devices and services that meet the needs of beneficiaries with complex, long-term or permanent, mobility and other impairments. CRT consists of individually configured manual and power wheelchairs, seating and positioning systems, and other adaptive equipment such as standing devices and gait trainers. The specialization inherent in CRT contrasts with the far less complex mobility devices under the DME benefit, which typically serve a short-term, post-hospitalization beneficiary population in need of DME while recovering in the home. In 2014, CRT power wheelchairs and accessories accounted for two percent (about 13,000) of all Medicare wheelchair utilization and 22 percent (about $69 million) of wheelchair expenditures.[1]

COMPETITIVE BIDDING

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program was enacted with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which required Medicare to implement a competitive bidding process for selected DMEPOS items to reduce beneficiary out-of-pocket expenses and save the Medicare program money.[2]

Under competitive bidding, suppliers compete in established competitive bidding areas by submitting bids for selected products. Not all products or items are subject to competitive bidding. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the single payment amount.

Notably, CRT power wheelchairs, but not other CRT products, were excluded from competitive bidding with the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. An exceptionally costly unanticipated expense, such as for CRT, can consume a large portion of the budgets of CRT device and service vendors, creating price pressures and/or potentially hindering beneficiary access. A July 2018 GAO report[3] found that competitive bidding of DME reduced payment levels substantially, with average reduction of 46 percent across the top 53 items. Rural areas are largely excluded from coverage in the bidding areas. DME vendors can compete in those non-bid areas and also refuse to provide services and products to those areas.

MIPPA acknowledged that complex rehabilitative power wheelchairs were unique and different from standard DME. However, the law did not establish a separate benefit/payment category for these wheelchairs and is limited in scope to apply only to certain complex rehabilitative power wheelchairs. Legislation would be needed to require that CMS create a separate and distinct classification for all products and services that are classified as CRT.

RELEVANT AMA POLICY AND ADVOCACY

Policy D-330.907 strongly encourages CMS to refrain from implementing policies that would curtail access to CRT wheelchairs and accessories by applying competitively bid prices to these specialized devices. If CMS does not refrain from implementing policies limiting access to CRT wheelchairs, the policy states that the AMA will encourage Congress to support legislation (e.g., HR 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Policy H-185.963 (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and (2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population.

Policy H-330.955 states that the AMA (1) continues to voice its objection to CMS and other insurers regarding onerous requirements for the prescription of durable medical equipment; (2) advocates that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that

the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician; (3) calls for CMS to revise its interpretation of the law, and advocates for other insurers, to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare or other insurer payment for durable medical equipment; and (4) calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

Policy H-390.835 supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

In accordance with Policy D-330.907, the AMA submitted a letter to the Secretary of Health and Human Services on June 9, 2016, urging CMS to revoke the application of competitive bidding to complex rehabilitation wheelchairs.

DISCUSSION

Referred Resolution 117-A-18 is consistent with AMA policy and past advocacy urging the CMS to rescind the decision to apply the competitive bidding pricing program to CRT wheelchairs and wheelchair accessories and instead develop alternative approaches that consider beneficiary access.

Accordingly, the Council recommends the essence of Resolution 117-A-18, while noting that accomplishing the request of the resolution will require legislation and regulation. Because CMS cannot enact legislation, the Council recommends supporting reclassification without referring to CMS as the necessary change agent. Once legislation is enacted, the Council's recommended policy statement of support for reclassification would direct the AMA to advocate for CMS implementation. The Council also recommends supporting the efforts of Federation partners to accomplish adequately funded CRT reclassification.

If CRT is categorized as a distinct category it should be adequately funded. In addition, to address concerns that prices for CRT products and services could increase significantly within a distinct category, the Council believes that it would be appropriate for CMS to develop additional requirements and/or regulations beyond those that currently exist for the fitting and prescribing of CRT under DME regulations. Such possible requirements/regulations could include, but not be limited to competitive bidding of CRT, coverage policies, and quality standards.

Finally, the Council encourages the ongoing involvement of appropriate stakeholders to accomplish the adequately funded reclassification of CRT, such as pain physicians, physical therapists, occupational therapists.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 117-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the reclassification of complex rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs. (New HOD Policy).

2. That our AMA support state medical association and national medical specialty society efforts to accomplish adequately funded reclassification of CRT. (New HOD Policy)

3. That our AMA support, upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services of additional requirements and/or regulations specific to CRT, beyond those that exist under the broad category of durable medical equipment. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] US Government Accountability Office. "Medicare: Utilization and Expenditures of Complex Wheelchair Accessories." June 1, 2016. Retrieved from https://www.gao.gov/assets/680/677602.pdf. Accessed February 19, 2019.
[2] Centers for Medicare & Medicaid Services. DMEPOS Competitive Bidding. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html. Accessed February 20, 2019.
[3] US Government Accountability Office. "Medicare Fee-For-Service: Information on the First Year of Nationwide Reduced Payment Rates for Durable Medical Equipment." July 2018. Retrieved at https://www.gao.gov/assets/700/693412.pdf. Accessed on February 21, 2019.

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
The Impact of Pharmacy Benefit Managers on Patients and Physicians
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-120.933, "Pharmacy Benefit Managers Impact on Patients." The Board of Trustees assigned the following provisions of the policy to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting:

> Our American Medical Association (AMA) will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; and (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.

PBMs no longer simply negotiate drug prices on behalf of their clients, but rather fully administer the drug benefit creating formularies, making coverage decisions, and determining medical necessity with utilization management tools. The Council believes that PBMs' role managing drug benefits now resembles the typical role of insurers, and they should be treated as such by regulators. Overall, regulators must better understand and control the costs to patients and the systems that are resulting from PBM practices. As such, the Council recommends that PBMs be actively regulated under state departments of insurance. To implement this new policy, the Council believes that our AMA should develop model state legislation addressing state regulation of PBMs. On the federal level, the Council believes that PBMs, like health plans, should be subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

The Council recognizes that the negative fluidity of the drug benefit is largely a result of the rebate system and the constant negotiations that take place to advance the interests of many drug benefit stakeholders – but not patients. The Council is concerned that the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor manufacturers currently have an incentive to lower list prices. As such, the Council questions whether rebates that are being negotiated by PBMs are resulting in any true savings. The disclosure of rebate and discount information, financial incentive information, and pharmacy and therapeutics (P&T) committee information would constitute critical steps toward improved transparency. The Council also believes that manufacturer rebates and pharmacy price concessions should be applied to drug prices at the point-of-sale. This policy, which also applies directly to DIR fees, would add much needed transparency and ensure that beneficiaries benefit from discounts, and dispensing physicians and practice-based pharmacies have more clarity regarding their true reimbursement rates.

In order to maintain cost transparency for patients and keep patients stable on their medications, the Council also recommends the reaffirmation of policies addressing mid-year formulary changes and utilization management requirements. These practices employed by PBMs can undermine the ability of patients to have timely access to the medically necessary treatment that they need.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-19

Subject: The Impact of Pharmacy Benefit Managers on Patients and Physicians

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
(John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-120.933, "Pharmacy Benefit Managers Impact on Patients." The Board of Trustees assigned the following provisions of the policy to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting:

> Our American Medical Association (AMA) will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; and (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.

This report provides background on PBM operations and market conditions, outlines issues of concern for patients and physicians with respect to PBM operations; and presents policy recommendations.

BACKGROUND: PHARMACY BENEFIT MANAGER OPERATIONS AND MARKET CONDITIONS

PBMs represent payers, including health insurers and self-insured employers, to negotiate discounts on the prices of prescription drugs and rebates based on volume of sales with pharmaceutical companies. In turn, payers determine which drugs to cover and how much patients pay. The role of PBMs as "middlemen" among payers, pharmaceutical companies and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. PBMs are more frequently fully administering the drug benefit of their clients, creating formularies, making coverage decisions, and determining medical necessity using utilization management tools. They also create networks of pharmacies and negotiate reductions in dispensing fees.

In general, PBMs have three primary revenue sources:

1. Fees from payers for claims administration and drug dispensing;

2. A percentage of the savings secured from rebates and discounts negotiated from pharmaceutical companies; and

3. Fees and savings associated with maintaining pharmacy networks.

The PBM market is highly concentrated: three PBMs – Express Scripts, CVS Caremark and OptumRx – control more than 70 percent of the market.[1] These three PBMs, by representing so many covered lives, have substantial bargaining power in their negotiations with drug manufacturers. Complicating the market concentration is the trend toward PBMs merging with health insurers, and how that could impact pharmacy networks available to patients. CVS-Aetna announced their proposed merger in December of 2017. The US Department of Justice (DOJ) has approved the CVS-Aetna merger, contingent on a federal court approving a settlement in which Aetna has agreed to divest its Medicare Part D prescription drug plan business. At the time this report was written, a federal court is reviewing that settlement. Cigna-Express Scripts announced their intention to combine in March of 2018. The Cigna-Express Scripts merger has been approved and is being consummated. Pertaining to PBM operations, the health insurers in these instances are trying to merge with the entity that is providing them with PBM and pharmacy services. Concerns have been raised by the AMA and others that the CVS-Aetna merger could substantially lessen competition in PBM services, health insurance, retail pharmacy, Medicare Part D, and specialty pharmacy.[2]

OPERATIONS OF PHARMACY BENEFIT MANAGERS: ISSUES OF CONCERN FOR PATIENTS AND PHYSICIANS

Insufficient Regulation

While most states have laws that regulate various aspects of PBM operations, such laws are rather limited in nature, and do not necessarily reflect the roles that PBMs have assumed in fully administering the drug benefit of their clients. State laws that regulate aspects of PBM operations generally fall into the following categories:

- Requiring a PBM to register with or be licensed by the state, in order to conduct business in the state;
- Specifying pharmacy audit procedures by PBMs, including outlining audit appeals mechanisms, audit notification requirements, how frequently audits can occur and what can be audited;
- Outlining conflict of interest provisions with respect to pharmacy and therapeutics (P&T) committees and other areas;
- Requiring transparency in the development and utilization of maximum allowable cost (MAC) lists, which list the maximum amount a PBM will pay for drugs;
- Prohibiting “gag clauses” in PBM-pharmacy contracts;
- Enacting “anti co-pay clawback” provisions that aim to prevent patient co-payments from exceeding the full cost of the drug;
- Imposing a fiduciary duty on a PBM to the entity with which it contracts; and
- Imposing a performance duty on a PBM, which requires a PBM to operate in good faith with the entity with which it contracts.

On the federal level, the function PBMs have assumed in administering the drug benefit of their clients raise the issue of if, and to what extent, PBMs are currently subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. Concerns have been raised that clarity is needed in this regard, as while they are not a health plan, they are operating very much like one pertaining to drug benefits.

AMA Policy and Advocacy Regarding Regulation

Policy D-185.995 puts PBMs on the same footing as public and private sector payers, by stating that our AMA will (1) advocate our policies related to health plan coverage of prescription drugs to PBMs, as well as to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs. Accordingly, the multitude of AMA policies addressing formulary requirements and transparency, utilization management, mental health parity and other issues are applicable to PBMs in addition to health plans.

Policy H-125.986 provides significant guidance with respect to federal regulation of PBM operations. The policy: 1) encourages the Federal Trade Commission (FTC) and the Food and Drug Administration (FDA) to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate; 2) states that certain actions/activities by PBMs and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; 3) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and 4) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interest and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.

In its comments in response to the *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint)* in July of 2018, the AMA outlined its support for regulating PBMs, stating that the benefit management of PBMs now resembles the typical role of insurers, and they should be treated as such by regulators. Also in July, the AMA submitted a letter in support of the efforts of the National Council of Insurance Legislators (NCOIL) in developing a draft state model act to require licensure of PBMs in the state and allow for oversight by the department of insurance or other equivalent regulatory agency. Additionally, the AMA has advocated for the National Association of Insurance Commissioners (NAIC) to include in its pharmacy benefit model legislation the regulation of PBM activities.

Lack of Transparency

The Council recognizes that the ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by the often byzantine and confidential arrangements that are driving increased medication prices without a clear and justifiable reason. The opaque nature of PBM negotiations of drug prices has raised questions whether the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor drug manufacturers currently have an incentive to lower list prices. In addition, there is a lack of transparency regarding what percent of the savings associated with rebates are passed through to patients or payers. The degree to which savings are passed on to payers and patients impacts health plan premiums as well as cost-sharing requirements.

Concerns have also been raised by physicians and their patients pertaining to transparency in formularies, prescription drug cost-sharing requirements, and utilization management requirements. This lack of transparency makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to any step therapy or other utilization

management requirements. For patients, lack of transparency in their drug coverage may lead to delays in necessary medication treatment, as well as being unaware of their formulary and cost-sharing responsibilities, which can lead to an inability to afford the medications they need. Such lack of transparency is exacerbated when formularies are changed mid-year, which can have negative effects on patients and can have a major impact on health care costs. Actions of PBMs to remove a medication from a patient's formulary during the middle of the plan year and replace it with another medication that is not effective for the patient – or which the patient has previously tried and not done well on – could result in potential trips to the emergency room and/or hospitalizations, increased out-of-pocket costs if the patient is responsible for paying for the drug, and potential physician and patient resources spent on appeals and alternative solutions.

AMA Policy and Advocacy regarding Transparency

The AMA has been highly engaged in efforts to promote the transparency of PBM practices and operations, resulting from the adoption of Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs and health insurance companies. Addressing mid-year formulary changes specifically, Policy H-125.979 states that drugs may not be removed from the formulary nor moved to a higher cost tier within a patient's health plan policy term. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthinRx.org, in 2016. At the time this report was written, more than 338,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency.

PBM transparency has also been a key theme highlighted in federal advocacy efforts related to drug pricing. In its comments in response to the proposed rule *Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees* in April 2019, the AMA supported applying manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale, and requiring PBMs to disclose a wide range of information, including additional information about their fee arrangements. In its statement for the record to the US House of Representatives Committee on Oversight and Reform on examining the actions of drug companies in raising prescription drug prices in January 2019, the AMA supported requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices; requiring increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections; and prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons. These concerns were echoed in the comments of the AMA submitted in response to *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint)* in July 2018.

In addition, in August 2018, the AMA submitted a letter in support of S 2554, the "Patient Right to Know Drug Prices Act," which has since become law. The law prohibits health insurers and PBMs from using "gag clauses" that prevent pharmacists from sharing with patients the lower cost options when patients are purchasing medically necessary medication. In addition, the law will ensure that the FTC will have the necessary authorities to combat anti-competitive pay-for-delay

settlement agreements between manufacturers of biological reference products and follow-on biologicals.

In March 2019, the AMA submitted a letter that supported HR 1781, the Payment Commission Data Act of 2019. If enacted into law, the bill would provide access to essential data that the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) need to evaluate the practices of various entities within the pharmaceutical supply chain that are either not readily available or not available at all for independent analysis, including drug pricing and rebate data. In its letter, the AMA noted that the lack of independent, data driven, third-party analysis of drug pricing and rebate data continues to hamstring additional efforts needed to combat anti-competitive business practices that undermine affordability and harm patients.

Concerning state-level advocacy, the AMA developed model state legislation entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year" (AMA Model Act), which addresses the issues of stabilized formularies and cost transparency. In particular, the AMA Model Act requires PBMs operating in the state to disclose any discounts or other financial consideration they received that affect the price and cost-sharing of covered medicines placed on a formulary. In addition, the AMA has model state legislation that prohibits clawbacks and standard gag clauses in pharmacy-PBM contracts.

PBM Clawbacks and Direct and Indirect Remuneration Fees

DIR is a term used by the Centers for Medicare & Medicaid Services (CMS) to refer to compensation Medicare Part D plan sponsors or their PBMs receive after the point-of-sale, including rebates provided by drug manufacturers and concessions paid by pharmacies. Concessions paid by pharmacies – which can include dispensing physicians and practice-based pharmacies – can comprise of network participation fees and reimbursement reconciliations. Such additional compensation after the point-of-sale, therefore, changes the final cost of drugs for payers, or the prices paid to pharmacies for drugs. In Part D, DIR impacts Medicare payments to Part D plans. However, DIR fees or similar fee mechanisms are being used in the commercial marketplace as well.

The concern raised in Policy D-120.933, was directed not toward the role of DIR in capturing rebates from pharmaceutical companies, but the impact of DIR fees on pharmacies. The Council recognizes that such fees have negatively impacted some physicians who conduct in-office dispensing and/or have practice-based pharmacies. If DIR fees are not collected from pharmacies on a real-time basis, but rather after transactions take place, pharmacies and affected physician specialties have raised concerns that there exists a lack of clarity regarding their true reimbursement rates. In addition, such entities have cited a need for additional transparency regarding how DIRs are determined and calculated.

In November 2018, the Centers for Medicare & Medicaid Services issued a proposed rule, "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses," that contains potential policy recommendations that would respond to the concerns raised in Resolution 225-A-18 concerning the impact of DIR fees on pharmacies. The proposed rule considers having DIR fees be accounted for and applied at the point-of-sale, which impacts the predictability of pharmacy reimbursement rates as well as patient cost-sharing.[3]

AMA Policy and Advocacy regarding Clawbacks and DIR Fees

Policy H-110.991 states that our AMA will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and PBMs that bar pharmacists from telling consumers about less-expensive options for purchasing their medication. Accordingly, in January 2019, the AMA submitted comments in response to the *Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses* proposed rule. In its comments, the AMA supported the proposed changes to the definition of "negotiated price" and other related changes that were outlined to ensure reduction in cost burden by beneficiaries at the point-of-sale for Part D prescription drugs, increased transparency, and enhanced competition among Part D plan sponsors. Further, the AMA noted that "when all pharmacy price concessions are not reflected in the price of a drug at the point-of-sale, beneficiaries do not benefit through a reduction in the amount that they must pay in cost-sharing and pay a larger share of the actual cost of a drug."

Utilization Management Requirements

When PBMs administer the drug benefits of payers, they have the ability to make coverage decisions and implement utilization management requirements that interfere with patients receiving the optimal treatment selected in consultation with their physicians. At the very least, utilization management requirements can delay access to needed care; in some cases, the barriers to care imposed by prior authorization and step therapy may lead to the patient receiving less effective therapy, no treatment at all, or even potentially harmful therapies. For physician practices, utilization management requirements often involve very manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care.

The 2018 AMA Prior Authorization Physician Survey provides insight into the impact that PBM utilization management requirements can have on patients and physician practices. In response to the survey, more than nine in 10 physicians (91 percent) responded that the prior authorization process delays patient access to necessary care, and three-quarters of physicians (75 percent) report that prior authorization can at least sometimes lead to patients abandoning a recommended course of treatment. In addition, more than nine in 10 physicians (91 percent) reported that prior authorization programs have a negative impact on patient clinical outcomes. Of significant concern, 28 percent of physicians reported that prior authorization led to a serious adverse event for a patient in their care. The survey findings also showed that every week, a medical practice completes an average of 31 prior authorization requirements per physician, which take the equivalent of nearly two business days (14.9 hours) of physician and staff time to complete. To keep up with the administrative burden, more than a third of physicians (36 percent) employ staff members who work exclusively on tasks associated with prior authorization.[4]

In addition, a US Department of Health and Human Services (HHS) Office of Inspector General (OIG) review of Medicare Advantage service denials in 2014-2016 reinforces the point that utilization management requirements can prevent patients from receiving medically necessary care. The OIG found that more than 116,800 prior authorization requests that were initially denied were eventually overturned on appeal. These overturned denials represent specific drugs/services that were medically necessary and the patient needed the treatment. The Council notes that this figure is particularly concerning because beneficiaries and providers appealed only one percent of denials.[5]

AMA Policy and Advocacy regarding Utilization Management Requirements

Policy H-320.939 supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. Policy H-285.965 outlines AMA policy objectives addressing managed care cost containment involving prescription drugs. Policy D-330.910 states that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the CMS and other appropriate organizations to resolve them. Policy H-320.958 states that our AMA will advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.

To educate the general public about the problems associated with prior authorization and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a grassroots website, FixPriorAuth.org, in July 2018. At the time that this report was written, there have been 10 million social media impressions, more than 500 patient and physician stories have been captured, and approximately 90,000 petitions have been signed.

In addition, the AMA has been very active in advocating for a reduction in both the number of physicians subjected to prior authorization and the overall volume of prior authorizations. In January 2017, the AMA and a coalition of state and specialty medical societies, national provider associations, and patient organizations developed and released a set of 21 Prior Authorization and Utilization Management Reform Principles intended to ensure that patients receive timely and medically necessary care and medications and reduce the administrative burdens. More than 100 other health care organizations have supported those principles. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and Medical Group Management Association in a Consensus Statement outlining a shared commitment to industry-wide improvements to prior authorization processes and patient-centered care. Additionally, the AMA has model legislation addressing prior authorization and utilization management programs that are often employed by PBMs, and works closely with many state and specialty medical societies to enact legislation each year.

Concerning federal advocacy, the AMA submitted comments in response to the *Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses* proposed rule, and raised significant concerns with the proposal to allow Part D plans to apply more prior authorization and step therapy requirements to protected class drugs. In its comments submitted in November 2018 in response to the proposed rule to modify Medicare regulations to promote program efficiency, transparency, and burden, the AMA urged CMS to reinstate its 2012 policy prohibiting Medicare Advantage plans from using step-therapy protocols for Part B physician-administered medications; and to carefully consider the care delays associated with prior authorization and the resulting impact on beneficiaries and their health and well-being when evaluating any additional prior authorization requirements for the Medicare program.

DISCUSSION

The Council recognizes that PBMs no longer simply negotiate drug prices on behalf of their clients, but rather fully administer the drug benefit creating formularies, making coverage decisions, and determining medical necessity with utilization management tools. The Council believes that PBMs' role managing drug benefits now resembles the typical role of insurers, and

they should be treated as such by regulators. Overall, regulators must better understand and control the costs to patients and the systems that are resulting from PBM practices. As such, the Council recommends that PBMs be actively regulated under state departments of insurance. To implement this new policy, the Council believes that our AMA should develop model state legislation addressing state regulation of PBMs. On the federal level, the Council believes that PBMs, like health plans, should be subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

The Council recognizes that the negative fluidity of the drug benefit is largely a result of the rebate system and the constant negotiations that take place to advance the interests of many drug benefit stakeholders – but not patients. The Council is concerned that the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor manufacturers currently have an incentive to lower list prices. As such, the Council questions whether rebates that are being negotiated by PBMs are resulting in any true savings. Moreover, the Council notes there is insufficient evidence regarding what percent of the savings associated with rebates are being passed through to patients or to payers.

To improve transparency in this space, the disclosure of rebate and discount information, financial incentive information, and P&T committee information would constitute critical steps forward. The Council also believes that manufacturer rebates and pharmacy price concessions should be applied to drug prices at the point-of-sale. This policy, which also applies directly to DIR fees, would add much needed transparency and ensure that beneficiaries benefit from discounts, and dispensing physicians and practice-based pharmacies have more clarity regarding their true reimbursement rates. As these policy changes are implemented, the Council believes that it will be essential to monitor their impact on premiums, medication list prices, and the discount/rebate structure.

In order to maintain cost transparency for patients and keep patients stable on their medications, the Council urges improved transparency in formularies, prescription drug cost-sharing, and utilization management requirements. Requirements and restrictions should be easily accessible by patients and prescribers and unless a change is made for safety reasons, PBMs and health plans should be prohibited from making changes during the duration of the patient's plan year. As such, the Council recommends the reaffirmation of Policy H-125.979.

Utilization management practices employed by PBMs can undermine the ability of patients to have timely access to the medically necessary treatment that they need. The Council notes that reaffirming existing AMA policies helps to highlight the need for new and additional efforts to track and quantify the impact of PBMs' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. Existing AMA policies also aim to protect patients in managed care cost containment practices involving prescription drugs, and state that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the CMS and other appropriate organizations to resolve them.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. (New HOD Policy)

2. That our AMA develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. (Directive to Take Action)

3. That our AMA support requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. (New HOD Policy)

4. That our AMA support efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. (New HOD Policy)

5. That our AMA support improved transparency of PBM operations, including disclosing:

    - Utilization information;
    - Rebate and discount information;
    - Financial incentive information;
    - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
    - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
    - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
    - Percentage of sole source contracts awarded annually. (New HOD Policy)

6. That our AMA encourage increased transparency in how DIR fees are determined and calculated. (New HOD Policy)

7. That our AMA reaffirm Policy H-125.979, which aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of the patient's plan year. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-320.939, which supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.965, which outlines AMA policy objectives addressing managed care cost containment involving prescription drugs. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy D-330.910, which states that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare & Medicaid Services and other appropriate organizations to resolve them. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-320.958, which states that our AMA will advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Preventive Prostate Cancer Screening
(Resolution 226-A-18)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 226, "Model State Legislation for Routine Preventive Prostate Cancer Screening," which was sponsored by the American Urological Association (AUA), the American Association of Clinical Urologists, and the Virginia Delegation. Resolution 226 asked that the American Medical Association (AMA) develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physicians without annual deductible or co-pay. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

Prostate cancer is one of the most common types of cancer that affects men. In the United States, men's lifetime risk of being diagnosed with prostate cancer is approximately 11 percent and their lifetime risk of dying of prostate cancer is 2.5 percent. African-American men and men with a family history of prostate cancer have an increased risk of prostate cancer compared with other men. In fact, older age, African-American race, and family history of prostate cancer are the most important risk factors for the development of prostate cancer. This report examines prostate cancer screening in the context of general costs of care concerns, the legal basis for coverage of preventive services without patient cost-sharing, whether prostate cancer screening has been shown to meet the criteria for benefits provided without patient cost-sharing, key clinical practice guidelines for prostate cancer screening, and the AMA's approach to cancer prevention and expanding affordable access to care.

The Council recommends that our AMA encourage payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. Additionally, the Council recommends that our AMA encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. The Council also recommends updating and expanding AMA policy regarding prostate cancer screening to encourage scientific research to address critical evidence gaps. In addition, the report describes extensive AMA policy that speaks to the resolves of referred Resolution 226-A-18. Accordingly, the Council recommends reaffirmation of policies which support: aligning clinical and financial incentives for high-value care, the role national medical specialty societies can play in helping to shape value-based insurance design (VBID) plans that decrease cost-sharing to encourage utilization of high-value services, VBID plans that explicitly consider the clinical benefit of a given service when determining cost-sharing structures or other benefit design elements, physician-patient shared decision-making and physician value-based decision-making, and coverage for evidence-based preventive services and genetic/genomic precision medicine.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-19

Subject: Preventive Prostate Cancer Screening
(Resolution 226-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
(John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 226, "Model State Legislation for Routine Preventive Prostate Cancer Screening," which was sponsored by the American Urological Association (AUA), the American Association of Clinical Urologists, and the Virginia Delegation. Resolution 226 asked that the American Medical Association (AMA) develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physicians without annual deductible or co-pay. The Board of Trustees assigned this item to the Council on Medical Service (CMS) for a report back to the House of Delegates at the 2019 Annual Meeting.

This report examines prostate cancer screening in the context of general costs of care concerns, the legal basis for coverage of preventive services without patient cost-sharing, whether prostate cancer screening has been shown to meet the criteria for benefits provided without patient cost-sharing, key clinical practice guidelines for prostate cancer screening, and the AMA's approach to cancer prevention and expanding affordable access to care.

BACKGROUND

Prostate cancer is one of the most common types of cancer that affects men.[1] In the United States, men's lifetime risk of being diagnosed with prostate cancer is approximately 11 percent and their lifetime risk of dying of prostate cancer is 2.5 percent.[2] African-American men and men with a family history of prostate cancer have an increased risk of prostate cancer compared with other men. In fact, older age, African-American race, and family history of prostate cancer are the most important risk factors for the development of prostate cancer.[3] As highlighted in the I-18 Joint Report of CMS and the Council on Science and Public Health (CSAPH), "Aligning Clinical and Financial Incentives for High-Value Care," more must be done to align incentives to support early prevention, detection, and treatment of disease, including cancer.

To ensure that patients get the medical care they need, they must be able to afford the full spectrum of care that they could require, from risk factor identification, to screening, to preventive interventions, to treatment of diagnosed disease. Even when a service is covered by a health plan, patients may incur significant costs in the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo not only unnecessary but also necessary care.[4] Cost-related non-adherence (CRN) refers to a state in which patients are unable to pursue recommended medical care due to financial barriers.[5] Sub-optimal use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and

in some cases, higher aggregate costs.[6] CRN has been identified across the entire continuum of clinical care – physician visits, preventive screenings, prescription drugs, etc. – and it is especially problematic for vulnerable populations, such as those with multiple chronic conditions, and for socioeconomically and racially disparate populations.[7]

ACA REQUIREMENTS & PREVENTIVE SERVICES BENEFIT MANDATES

A factor mitigating patient concerns about the cost of preventive care is the Affordable Care Act's (ACA) requirement that health plans cover select preventive services without any patient cost-sharing (zero-dollar). CMS and CSAPH recently examined the ACA's zero-dollar preventive services requirement in three joint reports:

- A-17, "Value of Preventive Services" (A-17 Joint Report);
- A-18, "Coverage for Colorectal Cancer Screening" (A-18 Joint Report); and
- I-18, "Aligning Clinical and Financial Incentives for High-Value Care" (I-18 Joint Report).

As detailed in the A-17 Joint Report, the ACA required all private, non-grandfathered health insurance plans to provide zero-dollar coverage for the preventive services recommended by four expert organizations: the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Women's Preventive Services Initiative, and Bright Futures (collectively, the Expert Organizations). The report also described the varied methods used by the Expert Organizations for developing preventive service guidelines. The A-17 report established Policy H-460.894, which encouraged the Expert Organizations to develop their recommendations with transparency, clarity and specificity.

The A-18 Joint Report on colorectal cancer screening is highly relevant in the current context as another close examination of a cancer screening that has been recently evaluated by the USPSTF and other medical guideline issuing organizations. Notably, the USPSTF had already recommended colorectal cancer screening with an "A" grade, making the screening eligible for zero-dollar coverage for some patients with ACA-compliant health plans. A critical challenge addressed in the A-18 Joint Report was inconsistency in ACA-compliant and Medicare coverage. Accordingly, the A-18 Joint Report established Policy H-330.877, which supports Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements.

The I-18 Joint Report explored various challenges that the health care industry has faced in implementing the zero-dollar coverage requirement, and it established Policy D-185.979 to help address those challenges. Specifically, Policy D-185.979 supports clinical nuance in value-based insurance design (VBID) to respect individual patient needs, aligning financial incentives across physician payment initiatives and benefit design initiatives, and encouraging national medical specialty societies to identify high-value services and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

The ACA's mandated zero-dollar coverage for select preventive services enjoys strong bipartisan support. A recent poll found that the ACA provision eliminating out-of-pocket costs for certain preventive services was favored by 83 percent of Americans.[8] However, before a service is mandated as a zero-dollar benefit in accordance with the ACA, it must be recommended by one of the Expert Organizations based on their review of the scientific evidence.

Meaning of USPSTF Recommendation Grading

Critically, to qualify for mandated zero-dollar coverage based on a USPSTF recommendation, a health care service must receive an "A" or "B" recommendation. Services that receive a "C" recommendation are supported by the USPSTF for certain patients, but they do not qualify for the ACA's zero-dollar coverage. The evidence supporting a given service determines the recommendation grade it receives. "A," "B," and "C" recommendations from the USPSTF all encourage provision of the service at issue, to some extent, with the recommendations varying based on the strength of the evidence in support of the service:

- "A" recommendations mean: "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." Accordingly, the USPSTF recommends that practitioners, "offer or provide this service."
- "B" recommendations mean: "The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial." As with an A recommendation, the USPSTF recommends that practitioners, "offer or provide this service."
- "C" recommendations are a bit more nuanced, and notably, the USPSTF's approach to "C" recommendations has evolved over the past two decades. Currently, a "C" recommendation means: "The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small." Accordingly, the USPSTF recommends that practitioners, "Offer or provide this service for selected patients depending on individual circumstances." In describing the evolution of the "C" recommendation, the USPSTF explains, "Grade C recommendations are particularly sensitive to patient values and circumstances. Determining whether or not the service should be offered or provided to an individual patient will typically require an informed conversation between the clinician and patient."[9]

The USPSTF can also issue a negative recommendation, a "D" recommendation, meaning: "The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits." Accordingly, the USPSTF recommends that practitioners, "Discourage the use of this service."[10]

Finally, the USPSTF can issue an "I" statement which means, "The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined." For these services, the USPSTF recommends that providers, "Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms."[11]

Few Cancer Screenings are Eligible for Zero-Dollar Coverage

Resolution 226-A-18 asserts that, "screening for breast cancer and colonoscopies are covered preventive services for patients without an annual deductible or co-pay." While that is true for some patients screened for breast and colorectal cancer, it is not true for many patients. Some cancer screenings (such as breast and colorectal cancer) for some patient populations have received an "A" or "B" recommendation from the USPSTF and are therefore provided for some patients without patient cost-sharing. This zero-dollar coverage, however, only results from the fact that the USPSTF has found evidence supporting an "A" or "B" level recommendation, indicating the net benefit of those services, for those populations. Accordingly, the cancer screenings that are

provided without patient cost-sharing are limited to those for which the existing evidence meets the USPSTF's standards.

As a result, many services that may be valuable to patients are not provided without cost-sharing when the existing evidence does not demonstrate that the net benefit is substantial or moderate leading to an "A" or "B" recommendation from the USPSTF. Prostate cancer screening is an excellent example. In assigning prostate cancer screening in men aged 55 to 69 years a "C" recommendation, the USPSTF explained that prostate cancer screening is recognized as valuable for some patients, but the evidence of benefits may not outweigh the potential harms for other patients.[12] Other critical services falling into the USPSTF's C recommendation category include screening mammography in women prior to age 50 years[13] and screening for colorectal cancer in adults aged 76 to 85 years.[14] Moreover, when the evidence for cancer screenings is lacking, the screenings receive an "I" recommendation from the USPSTF. Currently, these services include adult skin cancer,[15] bladder cancer,[16] and oral cancer.[17]

Currently, the only cancer prevention services with an "A" or "B" recommendations for any patient population are:

- Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer,[18]
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing,[19]
- Breast Cancer: Medications for Risk Reduction,[20]
- Breast Cancer: Screening,[21]
- Cervical Cancer: Screening,[22]
- Colorectal Cancer: Screening,[23]
- Lung Cancer: Screening,[24] and
- Skin Cancer Prevention: Behavioral Counseling (only applies to young adults, adolescents, children, and parents of young children).[25]

Moreover, among the cancer prevention services with "A" or "B" recommendations which are provided without cost-sharing, the recommendations are limited to specific patient populations. Accordingly, some patients for whom physicians would recommend these services fall outside the scope of the USPSTF recommendations, and therefore, the zero-dollar benefits do not apply to them. Relevant examples that the Council has examined in the A-18 and I-18 Joint Reports are:

- Breast cancer screening – "B" rating only applies to average risk women at certain ages. Screening for younger women is assigned a "C" recommendation, much like prostate cancer screening.[26] Moreover, women at heightened risk do not fall within the scope of the "B" recommendation. Accordingly, while some women will qualify for zero-dollar mammograms, others will not.
- Colorectal cancer screening – "B" rating only applies to average risk adults at certain ages.[27] Screening for older adults is assigned a "C" recommendation, and adults at heightened risk are outside the scope of the "B" recommendation. Once again, some adults will be able to receive a zero-dollar colorectal cancer screening, but others will not.
- Skin cancer prevention – the recommended scope of this cancer prevention service is even more limited. The USPSTF's "B" recommendation only applies to counseling, not screening, and for individuals aged 6 months to 24 years (or their parents). The USPSTF issued a "C" recommendation regarding counseling for adults with fair skin older than 24 years.[28] As a result, some patients can receive zero-dollar counseling regarding skin cancer prevention, but all skin cancer screenings would incur cost-sharing.

These examples illustrate that cost-sharing remains a concern not only for prostate cancer screening, but for other cancer screenings, too. At the same time, while cost-sharing is required, health insurance coverage for cancer screenings can help to defray the cost for insured patients.

RECOMMENDATIONS REGARDING PROSTATE CANCER SCREENING

The USPSTF's recommendations regarding prostate cancer screening are well-aligned with those of key medical specialty societies and other health care organizations. Prostate cancer screening has been reviewed repeatedly by the USPSTF,[29] and their most recent assessment is consistent with that of the AUA – both organizations recommend discussions of this service between a patient and his physician, and both recommend informed decision-making regarding whether to proceed with testing. Neither organization categorically recommends prostate cancer screening. For the AUA, this recommendation equates to a B on the AUA's scale,[30] while for the USPSTF, this recommendation equates to a C on the USPSTF's scale. These recommendations are also consistent with that of the American Cancer Society (ACS).[31] In addition to providing clinical guidelines, the ACS also takes an advocacy position supporting "insurance coverage" for prostate cancer screening, though it does not specifically call for zero-dollar coverage. [32] Notably, none of these three expert guidelines recommend universally screening any men of any age or risk category, and none of these evidence-based specialty guidelines justify a benefit mandate of zero-dollar coverage for prostate cancer screening in asymptomatic men ages 55-69.

EVIDENCE FOR CLINICAL GUIDELINES THAT INFORM COVERAGE DECISIONS

While the current evidence-based guidelines do not categorically recommend prostate cancer screening, the USPSTF has repeatedly highlighted evidence gaps, and with additional evidence, new, more precise recommendations, could be issued. When the USPSTF issued its 2018 recommendations on prostate cancer screening,[33] it explained that to update its 2012 recommendation, it commissioned two new reviews: a systematic review of the evidence regarding the benefits and harms of prostate-specific antigen (PSA)-based screening for prostate cancer and subsequent treatment of screen-detected prostate cancer, and a review of multiple contextual questions, including a review of existing decision analysis models and what they suggest about the potential for mitigating the harms of screening and treatment and the overdiagnosis rate of PSA-based screening. These studies also examined the effectiveness and harms of PSA-based screening in patient subpopulations at higher risk of prostate cancer, including older men, African American men, and men with a family history of prostate cancer. In addition, the USPSTF reviewed evidence from three randomized controlled trials (RCTs) studying PSA-based screening for prostate cancer: the US-based Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, the European Randomized Study of Screening for Prostate Cancer (ERSPC), and the Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP). These trials used varying screening intervals (from 1-time screening to every 1 to 4 years) and PSA thresholds (2.5 to 10.0 ng/mL) for diagnostic biopsy. These RCTs each had at least a decade of median follow-up.

Even with this additional research, the USPSTF emphasized that there are many areas in need of research to improve the evidence-base for screening and treatment of prostate cancer, including:

1. Comparing different screening strategies;
2. Developing, validating, and providing longer-term follow-up of screening and diagnostic techniques;
3. Screening for and treatment of prostate cancer in African American men, and specifying that given the large disparities in prostate cancer mortality in African American men, this research should be a national priority;

4. How to better inform men with a family history of prostate cancer about the benefits and harms of PSA-based screening for prostate cancer;
5. How to refine active prostate cancer treatments to minimize harms; and
6. How to improve informed decision-making.[34]

The USPSTF highlighted these critical research gaps in its November 2018 Report to Congress on *High-Priority Evidence Gaps for Clinical Preventive Services.*[35] Notably, screening for prostate cancer, especially among African-American men and men with a family history, is one of only three high-priority cancer-related evidence gaps that the USPSTF highlighted in 2018. This USPSTF report also explains that the National Institutes of Health (NIH) reviews the research gaps identified by the USPSTF and utilizes the information in developing future funding opportunities.

In addition, growing from a desire to find prostate cancer screening tools that better identify clinically significant prostate cancer, research into improved screening modalities is rapidly evolving. A variety of companies are developing urine or blood-based risk assays using precision medicine to identify aggressive cases of prostate cancer, with some products already available to physicians and patients.[36] For example, ExoDx Prostate (IntelliScore) (EPI) is a non-invasive urine-based liquid biopsy for prostate cancer which can accurately identify high-grade prostate cancer at the time of biopsy and at surgery.[37] As a "rule out" test, EPI is designed to more accurately predict whether a patient presenting for an initial biopsy does not have a high-grade prostate cancer, and therefore could be monitored while avoiding a biopsy at that time.[38] Similarly, MDx Health offers physicians and patients SelectMDx, an epigenetic urine test for prostate cancer risk stratification.[39] Additionally, prostate magnetic resonance imaging (MRI) prior to prostate biopsy can be used to help reduce overdiagnosis of insignificant cancer and improve detection of clinically significant cancer. Recent clinical studies[40] and a consensus statement of the AUA and the Society of Abdominal Radiology (SAR)[41] support the use of high-quality prostate MRI in detecting prostate cancer. However, some experts have raised concerns about both the appropriateness and practicality of advocating for widespread use of MRI to detect prostate cancer, emphasizing that more research is needed to evaluate the relative aggressiveness of high-grade tumors missed by prostate MRI, and that both the costs and the subspecialist expertise required to successfully perform MRI for prostate cancer detection may make widespread implementation of this tool impractical.[42] Currently, insurance coverage for precision medicine[43] and prostate MRI[44] can pose challenges for patients and their physicians. Accordingly, continued research into the efficacy of new and evolving screening and detection methods will be essential to inform clinical guidelines and standards of care, which can in turn influence insurance coverage determinations.

INSURANCE COVERAGE FOR PROSTATE CANCER SCREENING

The ACS explains that while some states have slightly different prostate cancer screening coverage requirements, "most state laws assure annual coverage for men ages 50 and over and for high-risk men [African-American men and/or men with a family history of prostate cancer], ages 40 and over."[45] Additionally, Medicare covers the PSA blood test and a digital rectal exam (DRE) once a year for all male beneficiaries age 50 and over. There is no co-insurance and no Part B deductible for the PSA test. Unlike some cancers where the costs associated with merely screening for the cancer can be prohibitively expensive (e.g., the myriad fees associated with colonoscopies or the potential for multiple different imaging fees associated with breast cancer screenings), the cost associated with a PSA test is relatively minimal. A 2013 study found, "During 2007–2009, the average annual prostate cancer screening cost per beneficiary was $36."[46] Similarly, the Medicare 2019 Clinical Lab Fee Schedule Payment for PSA is approximately $20. While $20-36 is certainly a barrier for some patients, it pales in comparison to the costs patients could later face if their PSA test is positive, and it pales in comparison to the cost of a colonoscopy.

As explored in the A-18 and I-18 Joint Reports, the current health care system does not successfully identify all high-value preventive services that are worthy of reduced patient cost-sharing, and VBID presents an opportunity for physicians to help shape the identification of additional high-value preventive services. The I-18 Joint Report established Policy D-185.979 which encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Prostate cancer screening could be an excellent example. Given the research gaps that will take time to fill and the powerful first-hand experience that physicians can share, physicians and payers could collaboratively evaluate prostate cancer screening to determine whether it should qualify as a high-value service, at least for certain patients, and be covered with reduced patient cost-sharing to encourage its utilization.

AMA POLICY

Many AMA policies support cancer prevention education, awareness, access and/or general insurance coverage, but they do not seek mandated zero-dollar coverage for specific cancer screening services. Key examples include:

- Breast and Cervical Cancers: Policies D-55.997, H-525.994, H-440.872, H-525.993, H-55.971, and H-525.977;
- Colorectal and Anal Cancers: Policies H-55.981, D-55.998, and H-460.913;
- Lung Cancer: Policy H-185.936;
- Skin Cancer: Policy H-55.972; and
- Prostate Cancer: Policies H-425.980 and D-450.957.

AMA policies that call for coverage with no cost-sharing broadly address categories of benefits, rather than individual disease states, including Policy H-185.969 regarding immunizations, Policy D-330.935 regarding Medicare preventive service benefits, and Policy H-290.972 regarding preventive coverage for health savings account holders in the Medicaid program. One exception, where AMA policy does seek zero-dollar coverage for a cancer screening, is for colorectal cancer screening (Policies H-185.960 and H-330.877). Critically, however, Policies H-185.960 and H-330.877 do not seek to establish a new zero-dollar benefit mandate; rather, they build on an ACA benefit mandate, seeking Medicare coverage on par with ACA-recognized evidence-based guidelines.

Longstanding AMA policy supports well-informed physician-patient shared decision-making regarding whether to pursue prostate cancer screening (Policy H-425.980), which is consistent with USPSTF, AUA, and ACS prostate cancer screening recommendations, as well as with AMA policy regarding many other cancer prevention efforts. Additionally, Policy H-373.997 sets forth core elements of physician-patient shared decision-making, and Policy H-450.938 sets forth the principles to guide physician value-based decision-making, including providing physicians with easy access to costs of care at the point of decision-making.

Extensive AMA policy supports insurance coverage for evidence-based preventive services (including Policies H-165.840, H-425.997, H-165.848, H-390.849, and H-185.954). Additionally, strong policy supports coverage and payment policies for evidence-based genetic/genomic precision medicine and encouraging national medical specialty societies develop clinical practice guidelines incorporating evidence-based precision medicine (Policy D-185.980).

Extensive AMA policy emphasizes the importance of collaboration with national medical specialty societies. Policies D-330.967 and H-425.987 support continued collaboration with national medical

specialty societies and interest groups to encourage coverage for evidence-based recommendations regarding preventive services, especially for populations at high risk for a given condition. Similarly, Policy D-185.979 encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Policy H-425.988 supports continuing collaboration with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services.

Long-standing AMA policy opposes benefit mandates. Policy H-165.856 sets forth principles to guide health insurance market regulation and states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements, and that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. At the same time, AMA policy strongly supports the provision of evidence-based preventive services without patient cost-sharing. AMA policy does recognize the limitations of the USPSTF and emphasizes the importance of relevant specialty physician input in guideline development. Policy D-425.992 expresses concern regarding the effect that USPSTF recommendations can have on limiting access to preventive care for Americans (e.g., regarding access to screening mammography and prostate specific antigen screening) and encourages the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study. Similarly, Policy D-450.957 specifically focuses on prostate cancer and the importance of including relevant specialty societies in guideline development.

Finally, AMA policy strongly supports VBID and innovative insurance design. Policy H-450.938 provides principles to guide physician value-based decision-making. Policy H-155.960 supports value-based decision-making and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a health care service or treatment, with consideration given to tailoring cost-sharing to patient income and other factors known to impact compliance. Policy H-185.939 supports flexibility in the design and implementation of VBID programs and outlines guiding principles, including that VBID consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Finally, Policy D-185.979 supports clinical nuance in VBID to respect individual patient needs.

DISCUSSION

The Council lauds the sponsors of referred Resolution 226-A-18 for highlighting the importance of prostate cancer screening and shares the goal of increasing access to this preventive service for appropriate patient populations. The Council is committed to developing AMA policy regarding prostate cancer screening that is consistent with the existing evidence-base, current clinical guidelines, and AMA policy. To accomplish this goal, the Council believes that the AMA should encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. Such policy would be consistent with the ACS recommendations for prostate cancer screening and AMA policy regarding various common cancers (Policies H-185.936, H-525.993, and H-55.981), as well as AMA policy regarding shared and value-based decision-making (Policies H-373.997 and H-450.938). Moreover, the resolution sponsors, the ACS, and the USPSTF all emphasize the importance of informed physician-patient shared decision-making in the context of prostate cancer screening, and the Council believes that the AMA should similarly emphasize this service. National medical specialty societies can play a critical role in promoting public education around the importance of informed physician-patient shared decision-making regarding prostate cancer

screening, and the Council encourages them to do so. In addition, the Council believes that, coupled with the new policies recommended in this report, reaffirming Policies H-373.997 and H-450.938 will help to emphasize the importance of well-informed shared physician-patient decision-making. Recognizing that the evidence-base for prostate cancer screening is rapidly evolving, and that more research is needed to better understand which patients should be screened, at which intervals, and with which tools, the Council recommends that Policy D-450.957 (see Appendix) be amended to change the title to read, "Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services," and to add a new subsection (3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services.

In addition, as improved, evidence-based methods for detecting clinically significant prostate cancer evolve, it will be essential that insurance coverage for medically necessary tests keep pace. Accordingly, the Council recommends reaffirming Policies D-185.980 and H-425.997 which support coverage for evidence-based genetic/genomic precision medicine and evidence-based, cost-effective preventive services. Moreover, prostate cancer screening, a service that is highly valuable to some patients and less necessary for others, is an outstanding example of how clinical nuance can be deployed through VBID to align clinical and financial incentives around care that is high-value for individual patients, consistent with Policy D-185.979. As also noted in Policy D-185.979, national medical specialty societies should play a key role in helping to shape VBID plans that decrease cost-sharing to encourage utilization of high-value services, and the Council recommends reaffirming that policy. Similarly, the Council believes that reaffirming Policy H-185.939 will emphasize the importance of VBID plans explicitly considering the clinical benefit of a given service when determining cost-sharing or other benefit design elements.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. (New HOD Policy)

2. That our AMA encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. (New HOD Policy)

3. That our AMA amend Policy D-450.957 to change the title to read, "Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services," and to add a new subsection, "(3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services." (Modify Current HOD Policy)

4. That our AMA reaffirm Policy D-185.979 regarding aligning clinical and financial incentives for high-value care and highlighting the role national medical specialty societies can play in helping to shape value-based insurance design (VBID) plans that decrease cost-sharing to encourage utilization of high-value services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-185.939 which supports VBID plans that explicitly consider the clinical benefit of a given service when determining cost-sharing structures or other benefit design elements. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-373.997, which sets forth core elements of physician-patient shared decision-making and Policy H-450.938, which sets forth the principles to guide physician value-based decision-making, including providing physicians with easy access to costs of care at the point of decision-making. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-185.980, which supports coverage for evidence-based genetic/genomic precision medicine and Policy H-425.997, which supports insurance coverage for evidence-based, cost-effective preventive services. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Amendment or Reaffirmation

Policy, D-185.979 Aligning Clinical and Financial Incentives for High-Value Care

1. Our AMA supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of "clinical nuance," recognizing that (a) medical services may differ in the amount of health produced, and (b) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (Joint CMS CSAPH Rep. 01, I-18).

Policy, D-185.980 Payment and Coverage for Genetic/Genomic Precision Medicine

1. Our AMA encourages public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that:
a. Promote transparency and clarity;
b. Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies;
c. Describe the evidence being considered and methods for updating the evidence;
d. Provide opportunities for comment and review as well as meaningful reconsiderations; and
e. Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival.
2. Our AMA encourages coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage.
3. Our AMA will work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact.
4. Our AMA encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services.
5. Our AMA supports continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine.

(Joint CMS / CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 06, A-18)

Policy, D-450.957 Draft Clinical Quality Measures Non-Recommended PSA-Based Screening
Our AMA will: (1) continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures; and (2) work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making. (Res. 225, I-15).

Policy, H-185.939 Value-Based Insurance Design
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:
a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (CMS Rep. 2, A-13 Reaffirmed in lieu of Res. 122, A-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16 Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 07, A-18 Reaffirmed: Joint CMS CSAPH Rep. 01, I-18)

Policy, H-373.997 Shared Decision-Making
Our AMA:
1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;

4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area. (CMS Rep. 7, A-10 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14)

Policy, H-425.997 Preventive Services
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.
(BOT Rep. A, NCCMC Rec. 31, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00 Reaffirmed in lieu of Res. 104, A-06 Reaffirmation A-07 Modified and Reaffirmed: Sub. Res. 101, A-08 Reaffirmed: CMS Rep. 03, I-16 Reaffirmed:
CMS Rep. 03, I-17)

Policy, H-450.938 Value-Based Decision-Making in the Health Care System
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING
1. Physicians should encourage their patients to participate in making value-based health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmation: I-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-19)

Introduced by: Indiana

Subject: Health Hazards of High Deductible Insurance

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Under the Affordable Care Act, high-deductible health insurance was allowed; and

Whereas, Patients were attracted to this option because of the lower premium costs; and

Whereas, Some patients under this plan tend to delay or defer treatment because their out-of-pocket cost is 100 percent until they spend $1,000 up to $5,000, dependent upon their plan. Studies of this population show that preventable diabetic complications are increased in patients insured under the high-deductible option, along with an increase in ER visits; therefore be it

RESOLVED, That our American Medical Association support health insurance deductibles of not more than $1,000 for an individual per year, especially to patients with significant chronic disease. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 03/06/18

RELEVANT AMA POLICY

Health Savings Accounts H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.
Citation: CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-19)

Introduced by: Illinois

Subject: Use of HSAs for Direct Primary Care

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, The healthcare system is constantly changing, and expanding access to quality medical care is a top priority of organized medicine; and

Whereas, There is predicted to be a shortage of primary care physicians over the next decade, and some primary care physicians are choosing Direct Primary Care (DPC) as a means to stay independent rather than be acquired or employed by a hospital or health system; and

Whereas, Direct Primary Care is an alternative payment model intended to improve access to highly functioning healthcare with a simple, flat affordable membership fee; and

Whereas, The defining element of DPC is an enduring and trusting relationship between a patient and his or her primary care provider; and

Whereas, The goal of DPC is better health outcomes, lower costs, and an enhanced patient experience, where there is no third-party billing; and

Whereas, Direct Primary Care is often referred to as “concierge” or “retainer” medicine; and

Whereas, Current IRS rules impede individuals with Health Savings Accounts (HSAs) from using these funds to pay for Direct Primary Care or even entering into periodic-fee DPC agreements because the current Internal Revenue Code (IRC) clearly states that HSAs must be paired with a high deductible health plan (HDHP), and Section 223(c) of the IRC also prohibits individuals with HSAs from having a second health plan to cover services not covered by the HDHP; and

Whereas, Current Treasury Department interpretation of the IRC treats Direct Primary Care monthly fee arrangements like a second health plan, rather than a payment for a medical service. Under current policy, individuals with HSAs are effectively barred from having a relationship with a DPC provider, because the DPC agreement makes the individual ineligible to fund the HSA; and

Whereas, 23 states have passed laws defining DPC as a medical service outside of health plan or insurance regulation, which would address some of the necessary concerns; and

Whereas, The Internal Revenue Code (IRC) is unclear about whether monthly payments to physicians practicing under the DPC model are considered a “qualified medical expense,” and when the regulations for HSAs were developed, DPC was not contemplated; and

Whereas, Two parts of the IRC need clarification; first, that DPC medical homes do not constitute a health plan under IRS Section 223(c), and second, that periodic payments to DPC practices for primary care services are to be treated as qualified medical expenses under IRC 213(d); therefore be it

RESOLVED, That our American Medical Association adopt policy that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense (New HOD Policy); and be it further

RESOLVED, That our AMA seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use Health Savings Accounts (HSAs) to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-19)

Introduced by: New York

Subject: Health System Improvement Standards

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Single Payer legislation in some states and in the US Congress has a real opportunity to become law; and

Whereas, Millions of patients with health insurance go without needed health care, or suffer financial hardship to get it, because of onerous deductibles, co-pays, restricted provider networks, out-of-network charges and unjustified denials of coverage; and

Whereas, Millions of people remain uninsured; and

Whereas, Sponsors and proponents of a state wide single-payer system believe that it will provide better coverage, at less cost, saving money for patients and government alike; and

Whereas, Regardless of where individual physicians stand on the issue of single payer health insurance, there are certain needed health system reforms for which most physicians would agree; and

Whereas, From an advocacy/strategy perspective, it would be helpful to identify health care principles that physicians and the public can seek and that could in turn provide the basis for alternatives to the current single payer proposals (and thus form the basis of a more cogent and unified physician message); therefore be it

RESOLVED, That our American Medical Association advocate for health care reform proposals that would achieve the following:

- Reduce the number of uninsured; and
- Reduce barriers to insured patients receiving needed health care, including ensuring full transparency of patient-cost sharing requirements, preventing unjustified denials of coverage, ensuring comprehensive physician networks, including through fair reimbursement methodologies, and providing meaningful coverage for out-of-network care; and
- Reduce administrative burden on physicians; and
- Prevent imposition of new costs or unfunded mandates on physicians; and
- Provide needed tort reform; and
- Provide meaningful collective negotiation rights for physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-19)

Introduced by: New York

Subject: Adverse Impacts of Single Specialty Independent Practice Associations

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Independent practice associations (IPAs) have been a health care fixture for some time; and

Whereas, Unlike an integrated medical group, IPA participating physicians maintain their separate medical practices, and use the IPA vehicle to pursue managed care contracts (based upon the societal benefits of practice transformation, integration of care, promotion of efficient care, elimination of redundancies and futile care, tied to proper reimbursement for this enhanced/high value care – as opposed to improperly utilizing market share and gatekeeper functions) that they could not obtain on their own; and

Whereas, Single specialty IPA's have become somewhat more common of late; and

Whereas, Single specialty IPA's have led to a greater interest in adverse payer policies such as capitation of physician services; and

Whereas, Compared to a multispecialty IPA, a specialty IPA is less likely to promote integration of care; and

Whereas, Some managed care plans have sought to drop participating physicians from its provider panel and to retain a physician only if the physician joins the company's contracted specialty IPA; and

Whereas, The typical IPA is a professional corporation with a panel of participating primary care physicians and a broad range of specialists, and a board that governs in a manner that promotes the interests of its member physicians; and

Whereas, The contracted specialty IPA selected by the managed care company may not at all represent the physician (and the community's) interests, but instead represents its own interests and those of the managed care company; therefore be it

RESOLVED, That our American Medical Association conduct a study relating to the impact of managed care plans replacing their participating physicians with those of a non-primary care physician single specialty independent practice association. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-19)

Introduced by: New York

Subject: Payment for Brand Medications When the Generic Medication is Recalled

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There have been many generic medication recalls recently in the United States because of poor manufacturing processes and oversight by the US Food and Drug Administration; and

Whereas, These recalls have resulted in medication shortages and have placed patients at risk; and

Whereas, Insurance companies and government programs will not pay for the brand medication that has not been recalled at the generic tier; and

Whereas, The Pharmacy Benefit Plans will not cover these medications, leaving a treatment and financial gap for patients; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services as well as third party payers to allow reimbursement for brand medications at the lowest copayment tier so that patients can be effectively treated until the medication manufacturing crisis is resolved. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-19)

Introduced by: New York

Subject: Raising Medicare Rates for Physicians

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Most physician payments are tied to the Medicare Fee Schedule; and

Whereas, The Medicare Fee Schedule is woefully inadequate for many physician codes and, in many regions, frequently well below the cost of providing the service; and

Whereas, The unsustainable Medicare Fee Schedule is probably the main reason physicians are going out of business in record numbers; therefore be it

RESOLVED, That our American Medical Association advocate strongly for raising the Medicare Fee Schedules for physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-19)

Introduced by: Ohio

Subject: Investigate Medicare Part D – Insurance Company Upcharge

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Each year, all insurers providing Medicare Part D coverage send the Government a detailed forecast of their projected cost for providing prescription drug coverage for the following year; and

Whereas, Under arcane rules, while insurers are directed to return to Centers for Medicare and Medicaid Services (CMS) any funds received exceeding 5% of their original estimate, but are permitted to keep any excess up to 5% for themselves; and

Whereas, According to a WSJ analysis of CMS data obtained via a public records request and published online, during the 2006-2015 period of review across all insurers, such direct subsidy estimates were over-estimated by $17.6 Billion, with plans actually keeping $9.1 Billion of those over-estimated funds; and

Whereas, All insurers were paid another $27.8 Billion to cover their reinsurance underestimates; and

Whereas, This process allows insurers to be protected from underestimating and paid extra for overestimating; therefore be it

RESOLVED, That our American Medical Association investigate Medicare Part D rules which allow providers to keep up to 5 % more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by Centers for Medicare and Medicaid Services reinsurance rules for certain losses. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-19)

Introduced by: Ohio

Subject: Congressional Healthcare Proposals

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, U.S. Congressmen and Senators are promoting “Medicare for all” proposals; and

Whereas, The concept is a single, government-controlled health insurance program that would cover every person in the United States; and

Whereas, The legislative language in one bill prohibits any private health insurer from offering any of the 10 statutorily designated categories of health benefits or specialized services authorized by Congress; and

Whereas, One House bill states “It is unlawful for a private health insurer to sell health coverage that duplicates the benefits provided under this Act”; and

Whereas, One House bill would prohibit Americans from purchasing any alternative health coverage, except for items such as “cosmetic surgery” and services the government deems “not medically necessary”; and

Whereas, A Senate bill prohibits any private health plan that “duplicates” the benefit coverage of the government’s national health insurance program; and

Whereas, The Senate bill also outlaws employer sponsored health insurance and the House and Senate bills abolish Medicare; and

Whereas, The House and Senate bills abolish Medicaid, CHIP (Children’s Health Insurance Program), and Obamacare health plans; therefore be it

RESOLVED, That our American Medical Association support provisions in Federal legislation that:

1. Do not limit the choices available for Americans for health care coverage
2. Support improving existing health plans
3. Make any new plan voluntary
4. Do not eliminate the private insurance market. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-19)

Introduced by: Ohio

Subject: Part A Medicare Payment to Physicians

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Physicians save millions of dollars in healthcare expenses by seeing patients in our offices, which are the least costly sites of service, paying careful attention to physical findings, diagnoses, and treatment plans for our patients; and

Whereas, Physicians reap little monetary benefit when our patients do well and do not require expensive hospitalizations and procedures, thus saving the patient and our health care system much expense; and

Whereas, Our AMA is currently conducting a study on *The Leading Role That Physicians Play in Reducing Medicare Spending*; and

Whereas, In this day of Value-based Healthcare, we believe this AMA study will show that we physicians indeed add value to our healthcare system, and that physicians should be adequately compensated for that value; therefore be it

RESOLVED, That our American Medical Association work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-19)

Introduced by: Ohio

Subject: Establishing Fair Medicare Payer Rates

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Medicare physician compensation is already unreasonably low; and

Whereas, Recent trends are that Medicare eligible patients are shifting to commercial Medicare PPO's and HMO's; and

Whereas, Commercial Medicare PPO's and HMO's discriminate against small physician practices by paying LESS than Medicare rates; therefore be it

RESOLVED, That our American Medical Association pursue Centers for Medicare and Medicaid Services (CMS) intervention and direction to prevent commercial Medicare payers from compensating physicians at rates below Medicare's established rates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-19)

Introduced by: Ohio

Subject: Practice Overhead Expense and the Site-of-Service Differential

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, In the 17-year period from 2001-2017, Medicare Part B payments to physicians increased only 6% while Medicare's index of inflation measuring the cost of running a medical practice increased 30%, (AMA Council on Medical Service (CMS) Report 4, I-18); and

Whereas, After adjustment for inflation in practice costs, physician pay has declined 19%, thus failing to match increases in office overhead costs (CMS Report 4, I-18); and

Whereas, In the 17-year period from 2001-2017, Medicare hospital payments increased roughly 50%, including average annual increases of 2.6% for inpatient services and 2.5% per year for outpatient services (CMS Report 4, I-18); and

Whereas, Hospitals have thus received payment increases more than 8-fold greater than payment adjustments to physicians in the period from 2001-2017; and

Whereas, Much of this disparate payment to hospitals is due to annual year- over-year increases in payments for services rendered in hospital outpatient facilities, where Medicare pays a so-called site-of-service differential amounting to, on average, approximately 360% of Medicare's payment for the same mix of services when they are performed in a physician's office; therefore be it

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-19)

Introduced by: Oklahoma

Subject: Health Care Fee Transparency

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Healthcare transparency is an important issue in Congress and in many states with innovative bills cropping up from coast to coast; and

Whereas, A 2018 Gallup Poll found that a greater percentage of Americans (55%) stated that they worry "a great deal" more about the availability and affordability of health care than about 14 other major social issues such as crime, the economy, unemployment, terrorist attacks, and the availability of guns[1]; and

Whereas, A 2018 study found that the median price of a magnetic resonance imaging (MRI) scan of the spine ranges from $500 to $1,670 in Massachusetts, which is also more than a 200-percent difference[1]; and

Whereas, American Medical Association CEO James L. Madera, MD wrote a letter to US Senators on 3/23/2018 stating "The lack of complete, accurate, and timely information about the cost of health care services prevents health care markets from operating efficiently"[2]; and

Whereas, Hospitals across the U.S. were required to post online their pricing for medical services on Jan. 1 2019 under a new federal law (CMS-1694-F)[3]; and

Whereas, While publishing prices is an effort to increase transparency, the data may do little to affect consumers and their healthcare costs--the information isn't easy to decipher and many other factors go into the bill patients eventually pay; and

Whereas, The proposed Department of Health and Human Services (HHS) rule, titled "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program," wants to take this a step further and require hospitals to disclose the prices they negotiate with health insurance companies to increase pricing transparency and reduce "surprise" medical bills[4]; and

Whereas, Under the price information section (pages 90-92) in the 187-page document, the HHS outlines a variety of changes the rule would put in place. This includes provisions such as requiring hospitals to share the entire pricing process, from list price to cost negotiated with a patient's health plan, including out-of-pocket expenses. It also mandates a tool so you could compare prices ahead of time and information on the cost of emergency services, such as ambulance rides[4]; and

Whereas, The proposed rule also states: Pricing information continues to grow in importance with the increase of high deductible health plans and surprise billing, which have resulted in an increase in out-of-pocket health care spending. Transparency in the price and cost of health

care would help address the concerns outlined above by empowering patients to make informed health care decisions[4]; and

Whereas, The American Hospital Association supports state-based efforts but may oppose the proposed pricing changes, saying patients only care about their out-of-pocket costs, not the whole pricing system[5,6]; and

Whereas, We believe it is in the best interest of our patients to know the cost of their health care prior to receiving the care and that a patient-based fee transparency model would be beneficial to our patients; therefore be it

RESOLVED, That our American Medical Association advocate for federal legislation and/or regulation to require disclosure of hospital prices negotiated with insurance companies in effort to achieve third-party contract transparency (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal legislation and/or regulation to require pharmaceutical companies to disclose drug prices in their television (TV) ads in order to provide consumers more choice and control over their healthcare. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18

References:

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6281149/
[2] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/issue-brief-strategies-increase-health-care-price-transparency.pdf
[3] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Regulations.html
[4] https://www.regulations.gov/document?D=CMS-2019-0039-0001
[5] https://www.aha.org/issue-brief/2018-05-04-hospital-price-transparency
[6] https://themighty.com/2018/12/nicole-vlaming-mental-health-hospital-bill-banner-health/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-19)

Introduced by: Washington, Connecticut

Subject: Ensuring Access to Statewide Commercial Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans; and

Whereas, Provider market power vastly exceeds exchange plans' market power in virtually every exchange market; and

Whereas, Current exchange options are extremely expensive in terms of premiums, deductibles, and out-of-pocket maximums; and

Whereas, Very few exchange participants have access to plans with statewide networks; and

Whereas, Limited network plans greatly increase an enrollee's financial risk to being subjected to excessive out-of-network providers' charges; and

Whereas, State employee benefit programs provide health insurance coverage to millions of state employees, retirees, and their dependents statewide in virtually every state; and

Whereas, State employee health plans' massive size enables them to negotiate very affordable premiums, deductibles, out-of-pocket maximums, and statewide coverage; and

Whereas, State employee health plans are not required to follow fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, retrospective audits and reviews, and medical necessity; and

Whereas, Requiring state employee benefit programs' insurers, as a condition of continued participation, to offer everyone coverage would greatly increase access, affordability, and choice nationwide; therefore be it

RESOLVED, That our American Medical Association study the concept of offering state employee health plans to every state resident, including exchange participants qualifying for federal subsidies, and report back to the House of Delegates this year (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that State Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

RELEVANT AMA POLICY

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
Citation: CMS Rep. 03, A-18

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred

method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.
Citation: BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-19)

Introduced by: Washington, Connecticut

Subject: Ensuring Access to Nationwide Commercial Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans (CMS Report 3, A-18); and

Whereas, Provider market power vastly exceeds exchange plans' market power in virtually every exchange market; and

Whereas, Current exchange options are extremely expensive in terms of premiums, deductibles, and out-of-pocket maximums; and

Whereas, Very few exchange participants have access to plans with nationwide networks; and

Whereas, Limited network plans greatly increase an enrollee's financial risk to being subjected to excessive out-of-network providers' charges; and

Whereas, The Federal Employees Health Benefits Program (FEHBP) provides health insurance coverage to approximately 8.2 million federal employees, retirees, and their dependents with an average of 24 plan offerings, most of which are nationwide fee for service plans available in all counties (CMS Report 3, A-18); and

Whereas, Federal employee health plans' massive size enables them to negotiate very affordable premiums, deductibles, out-of-pocket maximums, and nationwide coverage; and

Whereas, Federal employee health plans are not required to follow fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, retrospective audits and reviews, and medical necessity; and

Whereas, Requiring FEHBP insurers, as a condition of continued participation, to offer everyone coverage would greatly increase access, affordability, and choice nationwide; therefore be it

RESOLVED, That our American Medical Association advocate that Federal Employees Health Benefits Program health insurance plans should become available to everyone to purchase at actuarially appropriate premiums as well as be eligible for federal premium tax credits (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that Federal Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

RELEVANT AMA POLICY

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
Citation: CMS Rep. 03, A-18

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred

method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.
Citation: BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-19)

Introduced by: Wisconsin

Subject: Safety of Drugs Approved by Other Countries

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, All drugs sold in the United States have to be approved by the US Food and Drug Administration; and

Whereas, The thalidomide tragedy that occurred in early 1960s in Europe with approximately 10,000 infants being born with limb abnormalities was largely avoided in the United States because FDA inspector Francis Kelsey prevented the approval of the drug for use in the United States. Since that time the FDA has been hypervigilant about approving new medications which has improved patient safety but unfortunately has also been used by pharmaceutical companies to their benefit by making it more difficult to allow the market to work effectively in pharmaceuticals because of decreased competition; and

Whereas, The vigilance of the FDA and required testing of new drugs has increased the cost of development and testing of new medications to approximately $1 billion for each new medicine approved and this cost has led to new medicines not being tested and approved for use in the United States; and

Whereas, In Europe the EMA (European Medicines Agency) does a similar but not identical job in approving new medications in Europe for a smaller expense and therefore more drugs are available in Europe than are available in the United States and often at a significantly lower price; and

Whereas, The cost of pharmaceuticals in the United States is increasing rapidly and is recognized as a major medical problem with many people having difficulty affording their medications and wondering why they cannot obtain drugs approved in Europe which are often considerably less expensive; therefore be it

RESOLVED, That our American Medical Association compare the results of our US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) approval processes in terms of determining the safety and efficacy of pharmaceuticals using whatever data is available in order to determine whether the health of the citizens of the United States would be at risk if drugs approved by the EMA were imported and used as compared to the FDA (Directive to Take Action); and be it further

RESOLVED, That our AMA estimate what the reduction in the cost of medications would be for our patients if they were allowed to import EMA certified medications for use in the United States and thereby increasing competition for some of our current expensive pharmaceuticals. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/01/19

RELEVANT AMA POLICY

Prescription Drug Importation and Patient Safety D-100.983
Our AMA will:
(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;
(2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;
(3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation;
(4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts;
(5) support the in-person purchase and importation of Health Canada-approved prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity; and
(6) advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured.
Citation: BOT Rep. 3, I-04; Reaffirmation A-09; Reaffirmed in lieu of: Res. 817, I-16; Appended: CMS Rep. 01, I-18

Pharmaceutical Quality Control for Foreign Medications D-100.977
Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients.
Citation: Res. 508, A-08;A-16;A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-19)

Introduced by: Wisconsin

Subject: Medicare for All

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There is a lot of interest on the political scene in the term “Medicare for all” and yet no one seems to have a good definition of what this would really mean; and

Whereas, Medicare is a popular provider of health insurance for the elderly population of America along with some disabled Americans; and

Whereas, Most people do not understand the financial workings of Medicare but only see the benefits they derive from the system; and

Whereas, Physicians, medical clinics, hospitals, healthcare systems all have different experience with the Medicare system in terms of reimbursement as there are different rules for the different providers of care with each of these providers of care receiving different amounts of money for similar services which are different percentages of their cost for providing the care; and

Whereas, Many of the above providers of medical care receive less than the cost of providing that care under the current Medicare reimbursement formula while other providers may get significantly more reimbursement for the same service provided depending on whether the service is provided in a physician’s office, hospital, or hospital owned outpatient facility; and

Whereas, There is a feeling that “Medicare for all” would result in a diminution of the benefits in Medicare that the current elderly and disabled enjoy, but this is never really discussed: and

Whereas, Our AMA will be expected to provide information on how “Medicare for all” will affect the current Medicare program, the current medical practices of private practice physicians, medical clinics, hospitals and healthcare systems in order that we can inform our patients to enable them to make an informed choice when they vote for various candidates for office; therefore be it

RESOLVED, That our American Medical Association gather current, accurate data on the reimbursement from Medicare for private practice physicians, medical clinics, hospital outpatient services, hospitals including rural hospitals and critical access hospitals, and healthcare systems along with accurate data as to how the reimbursement compares to the cost for providing the medical care for these services (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate what would happen to the healthcare economics of the United States and the ability to continue outpatient medical practice if the current Medicare reimbursement, compared to the cost of providing that care, became the major financing resource for medical care and predict what effect this would have on the access to medical care in the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate how the current differential payments in Medicare to various entities for the same service would change in a " Medicare for all" scenario (Directive to Take Action); and be it further

RESOLVED, That our AMA, after analysis of the data, provide to the patients and physicians of our country the relevant questions that we can ask of political candidates advocating "Medicare for all" and (Directive to Take Action); and be it further

RESOLVED, That our AMA provide a better understanding of the impact of "Medicare for all" in terms of healthcare financing, workforce, ability to continue private practice medical care, incentives for physicians to join hospital systems, availability of care, and help understand how this might change the provision of healthcare in the United States. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Policy Timeline: Res. 717, I-07 Reaffirmation A-09)

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Policy Timeline: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18)

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. (Policy Timeline: Res. 118, I-91 Res. 102, I-92 BOT Rep. NN, I-92 BOT Rep. S, A-93 Reaffirmed: Res. 135, A-93 Reaffirmed: BOT Reps. 25 and 40, I-93 Reaffirmed in lieu of Res. 714, I-93 Res. 130, I-93 Res. 316, I-93 Sub. Res. 718, I-93 Reaffirmed: CMS Rep. 5, I-93 Res. 124, A-94 Reaffirmed by BOT Rep.1- I-94 CEJA Rep. 3, A-95 Reaffirmed: BOT Rep. 34, I-95 Reaffirmation A-00 Reaffirmation A-01 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 2, A-03 Reaffirmed and Modified: CMS Rep. 5, A-04 Reaffirmed with change in title: CEJA Rep. 2, A-05 Consolidated: CMS Rep. 7, I-05 Reaffirmation I-07 Reaffirmed in lieu of Res. 113, A-08 Reaffirmation A-09 Res. 101, A-09 Sub. Res. 110, A-09 Res. 123, A-09 Reaffirmed in lieu of Res. 120, A-12 Reaffirmation: A-17)

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
(Policy Timeline: BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-19)

Introduced by: Resident and Fellow Section

Subject: Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There are several non-contraceptive uses of hormonal contraception including treatment of abnormal uterine bleeding and endometrial hyperplasia; and

Whereas, Patients on Medicare disability insurance who present with abnormal uterine bleeding and/or endometrial hyperplasia may be poor surgical candidates thus limiting options to medical treatment with hormonal methods that may include contraceptive pills or long-term reversible contraception including the levonorgestrel intrauterine device; and

Whereas, Patients who are on Medicare disability insurance do not have coverage for contraception, including the levonorgestrel intrauterine device; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration -approved contraception for non-contraceptive use for patients covered by Medicare. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:
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2. AAFP News (2017). “AAFP Addresses Contraceptive Access and Coverage With FDA, CMS”. American Family Physician. Retrieved June 23 from www.aafp.org/news/health-of-the-public/20170821contraceptivesletter.html.
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4. Mosher, W., Bloom, T., Hughes, R., Horton, L., Mojtabai, R., & Alhusen, J. L. (2017). “Disparities in receipt of family planning services by disability status: New estimates from the National Survey of Family Growth”. Disability and Health Journal 10(3): 394-399. doi:10.1016/j.dhjo.2017.03.014
5. Pharr, J. R., & Bungum, T. (2012). “Health Disparities Experienced by People with Disabilities in the United States: A Behavioral Risk Factor Surveillance System Study”. Global Journal of Health Science 4(6):99-108. doi:10.5539/gjhs.v4n6p99

RELEVANT AMA POLICY

Coverage of Contraceptives by Insurance H-180.958
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.
Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17; Modified: BOT Rep. 10, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-19)

Introduced by: Oklahoma

Subject: Pharmaceutical Pricing Transparency

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Oklahoma patients continue to experience increases in pharmaceutical prices, and Pharmacy Benefit Managers (PBMs) create opacity in drug pricing; and

Whereas, PBMs act as middle men between insurers and drug manufacturers to determine which drugs will be covered by a health plan as part of a formulary; and

Whereas, Manufacturers wanting their drugs covered by health plans pay “rebates” to the PBMs, and manufacturers increase drug prices to offer the types of rebates necessary to keep their drugs in the formularies; and

Whereas, PBMs reimburse pharmacies for dispensing a medication, and the amount charged to the plan sponsor is often much higher than the reimbursement provided to the pharmacist for the drug, which is called “spread pricing”; and

Whereas, The PBM market has become a highly consolidated industry whose focus is not on serving consumers but on increasing company profits; therefore be it

RESOLVED, That our American Medical Association lobby for legislation that requires Pharmacy Benefit Managers to enhance drug-pricing transparency for the benefit of patients. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-19)

Introduced by: American Thoracic Society

Subject: Returning Liquid Oxygen to Fee Schedule Payment

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Medical oxygen is a prescription drug accessible only by physician prescription; and

Whereas, Clinical trials have demonstrated the effectiveness of supplemental oxygen to address hypoxemia, improve exercise tolerance, and reduce mortality for patients with respiratory or cardiac conditions; and

Whereas, Liquid oxygen is the optimal modality of delivering supplemental oxygen for patient with high flow rates (>4 liters/minute), patients who do not tolerate oxygen conservation devices or patients with high levels of ambulation; and

Whereas, Liquid oxygen systems were included into the CMS DME competitive bidding program; and

Whereas, Medicare beneficiary utilization of liquid oxygen has dropped significantly since its inclusion in the CMS DME competitive bidding program, dropping from 32,220 Medicare beneficiaries on stationary liquid system in 2010 to 5948 in 2016 and dropping from 40938 liquid portable Medicare beneficiaries in 2010 to 8141 in 2016; and

Whereas, Anecdotal reports from Medicare beneficiaries say DME companies who were awarded competitive bidding contracts refused to supply liquid oxygen even though they were contractually obligated to follow the physician prescription to provide liquid oxygen; and

Whereas, CMS in its proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2019 (CMS- 1691-P) recognized the problems in the liquid oxygen market but failed to propose or finalize policy that would meaningfully address problems with Medicare beneficiary access to liquid; therefore be it

RESOLVED, That our American Medical Association support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis (New HOD Policy); and be it further

RESOLVED, That our AMA convey its patient quality and access concerns for Medicare beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for Medicare and Medicaid Services, including the forthcoming proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2020. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/08/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-19)

Introduced by: Georgia

Subject: Medicare Coverage of Hearing Aids

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Nearly 30 million Americans have hearing loss; and

Whereas, The average price for economy, mid-level, and premium technology receiver-in-the-canal/ear hearing aids (RICs) is $1388, $2113, and $2789 each; and

Whereas, Medicare does not allow any reimbursement for RIC's and the 65+ year old patient who is in need of hearing amplification must pay for these devices out of pocket; and

Whereas, Untreated hearing loss has serious consequences and can result in depression, social isolation, anxiety about participating in social settings, and even paranoia, according to a study done by the National Council on the Aging; and

Whereas, The individual components of hearing aids cost anywhere from $50 to $150 per device, and there is no transparency into the wide disparity between the components and the ultimate price of a unit (one ear only) which can cost $2500; and

Whereas, Ninety percent of the RICs sold in the United States are manufactured by only six different companies; and

Whereas, If the cost of producing these devices could be brought down, and a patient had a supplement from Medicare to allow the purchase, that more seniors would be able to afford hearing amplification and enjoy the medical benefits that come with it; therefore be it

RESOLVED, That our American Medical Association urge Medicare to cover some or all of the costs of a "reasonable" device for both ears if a patient has had an audiological exam that identifies the need, and for Medicare to identify a vendor, or vendors, of hearing devices that produce a quality product without an exorbitant retail price. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
Citation: (CMS Rep. 6, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(A-19)

Introduced by: Michigan

Subject: Maintenance Hemodialysis for Undocumented Persons

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There are 11.3 million undocumented persons living in the United States and about 6,480 of these persons have end-stage renal disease (ESRD) for which undergoing routine hemodialysis or transplant are life-sustaining treatments; and

Whereas, In 2016, there were an estimated 100,000 undocumented immigrants living in Michigan that paid approximately $87.6M in state and local taxes and $15 billion in Social Security payroll taxes annually, and have added $300 billion to the $2.7 trillion Social Security Trust Fund; and

Whereas, Despite this substantial financial contribution to the American economy, undocumented immigrants are considered “not qualified” by the United States Department of Health and Human Services for 31 programs, resulting in denial of Medicaid, Medicare and CHIP; and

Whereas, Undocumented individuals are unable to access federal subsidization for renal transplant, therefore hemodialysis is the only treatment option for these patients; and

Whereas, Due to ineligibility for federal programs, most undocumented persons must pay out-of-pocket for hemodialysis, which is cost prohibitive. This renders hospital emergency services as the only option for care; and

Whereas, While emergency departments are mandated to provide coverage through the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) for emergent dialysis, they can only provide one to two sessions per week (rather than the recommended three sessions per week) and even then, high demand compromises the availability of dialysis chairs; and

Whereas, With a lack of consistent access to dialysis, many patients have experienced multiple cardiac arrests and resuscitations and severe psychosocial distress leading to significant, debilitating, and long-term health consequences that add further cost and burden to the health care system; and

Whereas, Emergency-only hemodialysis patients experienced a five-year mortality rate greater than 14-fold higher than patients undergoing scheduled maintenance dialysis, more ICU admissions, and an almost 10-fold greater use of acute-care days; and

Whereas, Emergency-only dialysis annually costs approximately $285,000 per patient versus $77,000 per patient for scheduled maintenance dialysis; and

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

Whereas, Eleven states and the District of Columbia are currently using state funding to provide undocumented persons with some maintenance dialysis coverage, including California which has changed its Medicaid policy to include “acute, ongoing, and maintenance renal hemodialysis” in its coverage of emergency services; and

Whereas, The Renal Physicians Association’s position on dialysis of undocumented individuals is as follows: “The federal government has a responsibility to provide care for all patients within the borders of the United States, and the financial burden of care provided to citizens and noncitizens is both a federal and state responsibility…difficult access to or denial of dialysis services will invariably hasten the patient’s demise and ultimate death;” therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify and advocate for equitable health care options to provide scheduled maintenance hemodialysis to undocumented persons. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Citation: Res. 006, A-17

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
Citation: (Res. 804, I-09; Appended: Res. 409, A-15

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Citation: Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.
Citation: Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17

Federation Payment for Emergency Services for Undocumented Immigrants H-160.917
Our American Medical Association supports federal legislation to extend Section 1011 of the Medicare Modernization Act (MMA, P.L. 108-173), which provides for federal funding to the states for emergency services provided to undocumented immigrants.
Citation: (Res. 212, I-09

Advancing Quality Coordinated Care for Patients with End Stage Renal Disease H-370.957
Our AMA will work with Members of Congress and their staffs to ensure that any legislation which promotes integrated and patient-centered care for End Stage Renal Disease (ESRD) patients does not inappropriately impinge on the patient-physician relationship and is in the best interest of ESRD patients.
BOT Action in response to referred for decision: Res. 219, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-19)

Introduced by: Michigan

Subject: Reimbursement for Telemedicine Visits

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Telemedicine can encompass a range of services from health monitoring and patient consultation to the transmission of medical records, but may be more broadly defined as any electronic exchange of health information (per the American Telemedicine Association), including the use of remote monitoring devices; and

Whereas, Telemedicine visits are increasing in frequency and have been shown to increase access, reduce 30-day hospital readmission rates, and reduce total cost of care; and

Whereas, Telemedicine services are also helping to fill gaps in health care faced by patients who struggle with mobility challenges, especially in rural communities; and

Whereas, Telemedicine services are also providing easy access for patients who appreciate receiving care in a more convenient manner, often with a lower cost to the patient than an in-office visit; and

Whereas, Primary care physicians are providing both synchronous (electronic exchange of health information with a real-time video component) and asynchronous (electronic exchange of health information without a real-time video component) telemedicine services for the benefit of patients with a concurrent liability risk for these services; and

Whereas, Reimbursement for telemedicine services is currently allowed only for synchronous telemedicine services (rural and non-rural settings) even though the expertise shared, and the liability risk incurred have similar value and associated risk with a synchronous or an asynchronous telemedicine visit; therefore be it

RESOLVED, That our American Medical Association work with third-party payers and the Centers for Medicare and Medicaid Services at the national level to provide reimbursement for both synchronous and asynchronous telemedicine services to encourage increased access and use of these services by patients and physicians. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

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.
Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18

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.
Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18

Insurance Coverage Parity for Telemedicine Service D-480.969
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Citation: Res. 233, A-16

Access and Equity in Telemedicine Payments D-480.970
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined “shortage” areas, if that area can show a shortage of those physician specialists.
Citation: Res. 818, I-14; Reaffirmed: CME Rep. 06, A-16

Teleconsultations and Medicare Reimbursement H-480.961
Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes.
Citation: (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

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

Whereas, Applied Behavioral Analysis (ABA) 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 learning[3,4]; and

Whereas, The effectiveness of ABA-based treatment programs has been well-documented through numerous studies across five decades of research, with strong empirical support for ABA as the most effective intervention for patients with Autism Spectrum Disorder[5-7]; and

Whereas, The American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics assert that ABA therapy can produce improvements in social relationships, self-care, school, employment, communication, and play in all age groups[8-10]; and

Whereas, Children who receive early, intensive ABA 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 ABA therapy[11]; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) require states to cover all medically necessary services for children, including ABA for Autism Spectrum Disorders, but allows individual state Medicaid agencies to determine what services are medically necessary for eligible individuals who are not children[12]; and

Whereas, There exists significant variability among state mandated maximum ages of eligibility for ABA and among insurance coverage variability, including caps in some states to no annual or lifetime cap[13]; and

Whereas, Studies indicate that significant cost avoidance or cost savings up to $208,500 per child may be possible with early and consistent implementation of the ABA model[14]; and

Whereas, The majority of the costs for Autism Spectrum Disorder treatment are in the form of adult-care ($175 billion compared to $61 billion for children), and the cost of lifelong care can be reduced by up to 66 percent with early diagnosis and intervention such as ABA therapy[2,15]; and

Whereas, The AMA already "urge[s] 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); therefore be it

RESOLVED, That our American Medical Association support the coverage and reimbursement for Applied Behavioral Analysis for the purpose of treating Autism Spectrum Disorder. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: 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 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.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

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.
Citation: Res. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 124
(A-19)

Introduced by: Medical Student Section

Subject: Increased Affordability and Access to Hearing Aids and Related Care

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Age related hearing loss (ARHL) is the most common sensory deficit, affecting more than two-thirds of adults over the age of 70, and evidence suggests that hearing impairments increase the risk of costly health outcomes including disability, depression, cognitive impairment, and dementia[1]; and

Whereas, 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]; and

Whereas, The primary treatment for hearing loss is a properly-fitted hearing aid and hearing aid use is associated with better hearing-specific as well as general health-related quality of life[3]; and

Whereas, While the cost of hearing aids varies, the average patients spends $2360 for one hearing aid and, as in most cases of ARHL, $4720 if they need two[4]; and

Whereas, 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 fewer than 1 in 5 adults who could benefit from hearing aids use them[1,5-7]; and

Whereas, 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[8]; and

Whereas, Only about half of the states have Medicaid programs that cover some aspects of hearing aids, exams, and related services, for adults[9]; and

Whereas, The Veterans Administration (VA) provides coverage for hearing aids and additional hearing-related services and is able to bulk-purchase hearing aids at an average of $400 per device, making it the country's largest and most efficient purchaser of hearing aids[10,11]; and

Whereas, Bundled pricing for hearing aids is a marketing strategy where patients have to pay for additional services in order to receive hearing aids, even if they do not require those services, further lessening access to hearing aids[19]; and

Whereas, There have been proposals to improve the access to hearing aid technology through unbundling pricing strategies, development of personal sound amplification devices, and approval of the OTC sale of hearing aids[12-20]; and

Whereas, 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]; and

Whereas, 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[21]; therefore be it

RESOLVED, That our American Medical Association support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly (New HOD Policy); and be it further

RESOLVED, That our AMA encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids (New HOD Policy); and be it further

RESOLVED, That our AMA support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by guaranteed renewability.
(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) Guaranteed issue regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
Citation: CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

Citation: (CMS Rep. 6, I-15

Early Hearing Detection and Intervention H-245.970
Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.
Citation: (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
Citation: CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 125
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Mitigating the Negative Effects of High-Deductible Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, High-deductible health plans disincentivize patients from seeking appropriate heath care; and

Whereas, The 2009 Affordable Care Act (ACA) requires that preventive services recommended by the US Preventive Services Task Force (USPSTF) be covered by insurers without a deductible; and

Whereas, Outpatient visits for the care of common conditions, such as hypertension, diabetes, coronary artery disease, hypothyroidism, etc., are not considered preventive, and therefore require that the patient pay in full for these visits, until the deductible is met; and

Whereas, As a result, many patients decide not to get appropriate care for their health conditions; and

Whereas, Several studies have found that improved access to a doctor's office to control chronic disease and provide early treatment of medical problems will reduce total health care costs through decreased use of emergency room and in-patient care[1]; and

Whereas, In addition to their adverse effect on patients' access to care, high-deductible health plans burden the economic viability of physician practices. While physicians are able to collect copayments at the time of the visit, we are not able to charge for a deductible until a claim for the visit has been submitted to the insurer, and the insurer has responded to the claim; and

Whereas, In the experience of many, physicians are usually not able to ascertain, at the time of service, how much of the patient's deductible has been met; even if a patient will eventually be found to be responsible for payment for the visit, the physician is unable to ask for payment at the time of the visit; and

Whereas, This delay in submitting the claim to the patient inexorably leads to a decrease in the collection rate for this portion of the fee. It is well known among private practice physicians that there is a steady decrease in collection rate as time goes on after the visit; and

Whereas, In summary, high-deductible plans have a negative impact on patient health, may increase total health care costs, and pose a threat to the economic viability of physician practices; and

Whereas, One change that would provide significant relief to both patients and physicians would be to exempt outpatient physician evaluation and management codes (99201–05 and 99211–15) from the deductible, for primary care and specialty practices; and

Whereas, There is precedent for this policy, in that the ACA requires that insurance plans exempt preventive services recommended by the USPSTF from deductible payments; and

Whereas, Exempting these codes from payment of the deductible would improve patient access to needed care, would likely reduce utilization of emergency room and in-patient services, and would help to stabilize the economic viability of physician practices; therefore be it

RESOLVED, That our American Medical Association advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

[1]Nielsen M, Buett L, Patel K, Nichols L (2016). Patient Centered Medical Home's impact on cost and quality, review of the evidence 2014–15. http://www.pcpcc.org/resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 126
(A-19)

Introduced by:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject:	Ensuring Prescription Drug Price Transparency from Retail Pharmacies
Referred to:	Reference Committee A (John Montgomery, MD, Chair)

Whereas, The AMA has policy supporting both prescription drug price transparency as well as improved access to information about prescriptions drug prices and out-of-pocket costs for patients; and

Whereas, The AMA does not have an updated policy addressing the fact that less expensive purchasing options, such as alternative medications or generic formulations, may be available to physicians at time of prescribing and patients at the time of purchase at a retail pharmacy; and

Whereas, The Administration has recently removed pharmacy 'gag clauses', banning retail pharmacy restrictions on informing patients about differences in drug price with insurance coverage, copayment, and out-of-pockets price of the medication, highlighting the importance of price transparency on a federal level;[1,2] and

Whereas, Most physicians and patients have limited access to the out-of-pocket cost of medications due to the complexity of copays and formularies on different insurance plans, prices and costs at different pharmacies; and

Whereas, Health and Human Services is in the early stages of determining how to utilize "Real-Time Benefit check" to implement across all systems; and

Whereas, Barriers against prescription drug price transparency continue to limit the efficiency and effectiveness with which health care providers can support informed clinical and financial decision making for their patients;[3] therefore be it

RESOLVED, That our American Medical Association amend policy H-110.991, "Price of Medicine," by addition and deletion as follows:

Our AMA:
(1) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard; ~~(1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;~~
(2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication;
(3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price;
(4) will disseminate model state legislation to promote drug price and cost transparency ~~and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication~~; and
(5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale. (Modify Current HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

1. Patient Right to Know Drug Prices Act. https://www.congress.gov/bill/115th-congress/senate-bill/2554/text
2. Know the Lowest Price Act.
3. The Risky Game One Doctor Plays To Help Patients Find Affordable Insulin. https://www.wbur.org/commonhealth/2018/04/19/insulin-drug-pricing-pharmacy

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patients co-pay is higher than the drugs cash price;(4) will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit clawbacks and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; and (5) supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.
Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10.Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade

Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11.Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18;

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.
Citation: 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; Reaffirmed: BOT Rep. 14, A-18

Drug Price and Cost Transparency D-110.988
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.
Citation: Alt. Res. 806, I-17

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.
Citation: 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; Reaffirmed: BOT Rep. 14, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-19)

Introduced by: New Jersey

Subject: Eliminating the CMS Observation Status

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, “Observation Status” for a hospitalization does not count to meet Medicare’s “three day inpatient rule” for “skilled nursing facility care” financial coverage; and

Whereas, “Observation Status” to a hospital means our patients are financially responsible for a 20 percent co-pay for hospital costs, the full cost of medications and diagnostic testing; and

Whereas, Our patients should present for emergency care assessment as soon as symptoms and/or signs dictate, but the financial risks of “Observation Status” may dissuade patients from seeking hospital based care through the emergency department; and

Whereas, Medicare Part A patients do not get a thorough explanation, including situational examples, of Medicare coverage rules for “Observation Status” when pre-admitted or admitted to a hospital; and

Whereas, There is no insurance available for Part A “Observation Status” financial risk; therefore be it

RESOLVED, That our American Medical Association request, for the benefit of our patients’ financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the “48 hour observation period” and observation status in total. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Reference Committee B

BOT Report(s)

09 Council on Legislation Sunset Review of 2009 House Policies

14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing: Negotiated Payment Schedules

17 Ban on Medicare Advantage "No Cause" Network Terminations

18 Increased Use of Body-Worn Cameras by Law Enforcement Officers

19 FDA Conflict of Interest

20 Safe and Efficient E-Prescribing

21 Augmented Intelligence in Health Care

22 Inappropriate Use of CDC Guidelines for Prescribing Opioids

23 Prior Authorization Requirements for Post-Operative Opioids

30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs

Resolution(s)

201 Assuring Patient Access to Kidney Transplantation

202 Reducing the Hassle Factor in Quality Improvement Programs

203 Medicare Part B and Part D Drug Price Negotiation

204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs

205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary

206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade

207 Direct-to-Consumer Genetic Tests

208 Repeal or Modification of the Sunshine Act

209 Mandates by ACOs Regarding Specific EMR Use

210 Air Ambulances

211 Use of FAIR Health

212 Pharmacy Benefit Managers

213 Financial Penalties and Clinical Decision-Making

214 The Term Physician

215 Reimbursement for Health Information Technology

216 Eliminate the Word Provider from Healthcare Contracts

217 Medicare Vaccine Billing

218 Payment for Medications Used Off Label for Treatment of Pain

219 Medical Marijuana License Safety

220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders

221 Extending Medicaid Coverage to 12-Months Postpartum

222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads

223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record

224 Extending Pregnancy Medicaid to One Year Postpartum

225 DACA in GME

226 Physician Access to Their Medical and Billing Records

227 Controlled Substance Management

228 Truth in Advertising

229 Clarification of CDC Opioid Prescribing Guidelines

Contained in the Handbook Addendum

Reference Committee B

Resolution(s)

230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes

231# Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability Act

232# COPD National Action Plan

233# GME Cap Flexibility

234# Improved Access to Non-Opioid Therapies

235# Prescription Coverage of the Lidocaine Transdermal Patch

236# Support for Universal Basic Income Pilot Studies

237# Opportunities in Blockchain for Healthcare

238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis

239# Improving Access to Medical Care Through Tax Treatment of Physicians

240# Formation of Collective Bargaining Workgroup

241# Facilitation of Research with Medicare Claims Data

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-A-19

Subject: Council on Legislation Sunset Review of 2009 House Policies

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) policy database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - RECOMMENDED ACTIONS ON 2009 HOUSE POLICIES

Policy Number	Title	Text	Recommendation
D-160-939	Physician Supervision Over Certified Registered Nurse Anesthestists	Our American Medical Association will urge the federal government to repeal the opt-out provision of the Medicare Conditions of Participation that eliminated the long-standing requirement that certified registered nurse anesthetists practice under direct physician supervision. Citation: (Res. 213, I-09)	Retain. This policy remains relevant.
D-270.998	Oppose Scope of Limited English Proficiency Guidance	Our AMA BOT, to the fullest extent appropriate, will authorize further efforts necessary to actively oppose the inappropriate extension of the Limited English Proficiency Guidance issued by the US Department of Health and Human Services' Office of Civil Rights' to physicians ~~in private practice~~ who receive Federal financial assistance from HHS. Citation: (Res. 216, I-00; Reaffirmation A-09)	Retain, but make a technical edit.
D-275.996	Creation of AMA Data Bank on Interstate Practice of Medicine	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~~ internet 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. Citation: (BOT Rep. 6, I-99; Reaffirmed: CLRPD Rep. 1, A-09)	Retain. This policy remains relevant, but modify the term "World Wide Web" for "internet."
D-315.993	Physicians as Patients: Their Right to Confidentiality	Our AMA will consider for possible intervention pending and future court cases in which the principles of informed consent are inappropriately expanded to require disclosure of a physician's impairment, including substance abuse problems, or information otherwise protected by laws governing patient privacy and confidentiality. Citation: (BOT Rep. 17, I-99; Reaffirmed: CEJA Rep. 8, A-09)	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
D-330.993	Explanation of Public-Private Partnerships that Exist between Government and the AMA	Our AMA: (1) continues to employ a variety of tactics to advocate CMS adoption of AMA policy positions; (2) continues to work cooperatively with CMS, when possible, to achieve its policy objectives; (3) when advocacy efforts directed at CMS fall short of achieving AMA policy objectives, the AMA continue to seek congressional action, including oversight hearings and enactment of legislation; and (4) use appropriate legal means, including suing CMS, when appropriate and warranted. Citation: (BOT Rep. 17, A-99; Reaffirmed: CLRPD Rep. 1, A-09)	Retain. This policy remains relevant.
D-385.965	Insurance Companies Use of Contractors to Recover Payments	1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made. (a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid. (b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians. 2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans. Citation: (Res. 215, A-09)	Retain. This policy is remains relevant.
D-435.973	Quantifying Medical Tort Reform	Our American Medical Association will 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. Citation: (Res. 216, I-09)	Rescind. Policy is implemented. AMA on an annual basis publicly issues MLR Now!, which includes costs of defensive medicine, financial impact, and state and federal efforts in liability reform.

Policy Number	Title	Text	Recommendation
D-455.994	Standardizing Portable Medical Imaging Formats to Enhance Safe, Timely, Efficient Care	1. Our American Medical Association will participate in efforts to ensure implementation of the recommendations for imaging standards developed by the AMA-convened imaging safety and standards Panel, that the Radiological Society of North American (RSNA) endorsed and Integrating the Healthcare Enterprise (IHE) adopted and wrote into the portable data initiative standards. 2. Our AMA will develop a strategy to inform the health care and imaging communities of the AMA's work to improve Imaging Safety and Standards that includes the following: a. Disseminate (widely) the AMA-convened Panel's statement, "All medical imaging data distributed should be a complete set of images of diagnostic quality in compliance with those found in the IHE PDI (Portable Data for Imaging) Integration Profile;" b. Publish the Panel's work; c. Increase hospital group, deeming organization, medical group, and survey certification group awareness of the AMA's work; determine their role in developing infrastructure support for medical imaging safety per AMA recommendations and IHE-PDI standards; d. Expose the AMA's work to the Office of the National Coordinator; e. Encourage industry to view physicians as developers rather than solely as adopters of technology and to include physicians, as end users, in the development and implementation of technology solutions; and, f. Encourage physicians, as end users of technology, to participate in development and implementation of technology to ensure its appropriate use and application at the point of care. Citation: (BOT Rep. 1, I-09)	Retain. This policy remains relevant.
D-478.986	Information Technology and Stimulus Money	Our AMA: will (1) caution health care policy makers that the Health Care Information Technology stimulus money, as outlined in the American Recovery and Reinvestment Act, will cause a sudden rise in the demand for health care IT products	Retain. This policy is remains relevant.

Policy Number	Title	Text	Recommendation
		and services which may result in inflated prices for physicians; and (2) advise physicians and health care policy makers that the ongoing maintenance of health care IT can be costly, and that this ongoing expense will fall to physicians long after the stimulus money is exhausted. Citation: (Res. 227, A-09; Reaffirmation I-09)	
D-65.993	Pain and Suffering in Darfur	Our American Medical Association will write to Secretary of State Hillary Rodham Clinton, the World Medical Association, and the World Health Organization in reference to the complex situations in Darfur and Sri Lanka, stating (1) our concerns related to the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) that we support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and that we condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, as has occurred in Darfur and Sri Lanka, and (3) that our AMA will advocate for the protection of physicians' rights to provide ethical care without fear of persecution. Citation: (BOT Action in response to referred for decision Res. 620, A-09)	Rescind. This directive has been accomplished.
D-70.997	Negotiated Rulemaking for Lab Tests	Our AMA: (1) reaffirms its policy to seek repeal of Section 4317 of the Balanced Budget Act of 1997 granting the Secretary of HHS authority to require submission of diagnosis codes with every lab test claim and with all claims for services provided by an entity other than the ordering physician; (2) continues to urge CMS to clarify and improve the Advanced Beneficiary Notice process; and (3) will work to modify the regulations forthcoming in the implementation of the Health Insurance Portability and Accountability Act (HIPAA) to conform with AMA policy. Citation: (BOT Rep. 11, A-99; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-120.941	e-Prescribing of Scheduled Medications	Our American Medical Association supports action requiring that the US Drug Enforcement Administration move expeditiously to establish reasonable requirements enabling the use of e-prescribing for controlled substances. Citation: (Res. 211, I-09)	Rescind. The SUPPORT Act (Public Law 115-271) mandates DEA to improve its EPCS regulations.
H-120.959	DVA Non-Physician Prescribing Authority	Our AMA will continue to pursue appropriate regulatory, legislative and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications. Citation: (Sub. Res. 220, A-99; Reaffirmed: CMS Rep. 11, I-99; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-120.996	Prescribing Eye Medications	Our AMA (1) reaffirms its policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or apply eye medications; and (2) continues to urge that state medical societies oppose legislation or administrative attempts to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury. Citation: (Sub. Res. 76, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation A-99; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-125.999	Drug Substitutes	Our AMA (1) supports continued efforts to inform the public and the profession of the potential problems and risks should a physician's choice of therapeutic agents be delegated to non-physicians; and (2) asks that state medical associations provide scientific and economic reasons in support of this position to state legislatures considering enactment of laws on substitution of drug products other than those prescribed or agreed upon by an attending physician.	Retain. This policy remains relevant.
H-160.917	Federation Payment for Emergency Services for Undocumented Immigrants	Our American Medical Association supports federal legislation to extend Section 1011 of the Medicare Modernization Act (MMA, P.L. 108-173), which provides for federal funding to the states for emergency services provided to undocumented immigrants. Citation: (Res. 212, I-09)	Rescind. This directive is no longer needed. MMA §1011 provided $250M per year for federal fiscal years 2005 through 2008 for payment to hospitals, physicians

Policy Number	Title	Text	Recommendation
			and ambulance providers for emergency health services provided to undocumented aliens and certain other specified aliens. The funding expired over a decade ago and has never been renewed.
H-160.936	Comprehensive Physical Examinations by Appropriate Practitioners	AMA policy supports the position that performance of comprehensive physical examinations to diagnose medical conditions be limited to licensed MDs/DOs or those practitioners who are directly supervised by licensed MDs/DOs; and the AMA will actively work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs/DOs. Citation: (Sub. Res. 210, I-96; Reaffirmed: BOT Rep. 34, A-06; Reaffirmed in lieu of Res. 235, A-09)	Retain. This policy remains relevant.
H-160.972	Physician Representation on State and National Health Care Advisory Bodies	The AMA urges Congress, and others who select members of state and national health advisory bodies, to increase the proportion of physicians in active clinical practice serving on these bodies, with selected members being recommended by state or national medical associations. Citation: (Sub. Res. 110, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-175.980	Anti-Kickback Implications of Ambulance Restocking	Our AMA: (1) supports federal legislation to create a safe harbor under the anti-kickback statute for ambulance restocking by hospitals, such as H.R. 3247, the "Community Safety Act of 1998;" and (2) urges the Office of the HHS Inspector General to change its position, as expressed in two existing advisory opinions, that hospital restocking of ambulances on a gratis basis may constitute a violation of the anti-kickback statute.	Rescind. This policy has been implemented. In 2001, the Office of Inspector General finalized a regulatory safe harbor regarding ambulance restocking by hospitals (42 C.F.R. 1001.952(v); 66 Fed. Reg. 62979). This safe harbor is available for

Policy Number	Title	Text	Recommendation
		Citation: (BOT Rep. 17, I-98; Reaffirmed: BOT Rep. 23, A-09)	free (or gratis) restocking arrangements, as well as arrangements under which the ambulance provider pays some amount for the restocked drugs and supplies (whether or not the amount is fair market value).
H-215.974	Not-For-Profit Boards	Our AMA seeks by whatever appropriate means available to change IRS requirements to allow more than 50% of a not-for-profit health care entity and/or hospital Board to be interested parties who are MDs or DOs. Citation: (Res. 222, A-98; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-220.932	Life Safety Code	Our AMA urges CMS to adopt the most current "Life Safety Code" as expeditiously as possible. Citation: (Res. 827, A-99; Reaffirmed: CMS Rep. 5, A-09)	Retain. This policy remains relevant.
H-275.925	Protection of the Titles "Doctor," "Resident" and "Residency"	Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (2) supports state legislation that would make it a felony to misrepresent oneself as a physician (MD/DO). Citation: (Sub. Res. 232, A-08; Reaffirmation I-09; Reaffirmed: BOT Rep. 9, I-09)	Retain. This policy remains relevant.
H-275.943	Public Education about Physician Qualifications	The AMA will continue to develop programs to educate the public about the differences in education and professional standards between physicians and non-physician health care providers. Citation: (Res. 623, A-96; Reaffirmation A-99; Reaffirmed: CLRPD Rep. 1, A-09)	Retain. This policy remains relevant.
H-285.937	Surgical Pathology in Managed Care	Our AMA will develop model legislative and regulatory language for states to insure that managed care plans: (1) which require surgical pathology specimens to be sent to specified laboratories, provide a list of qualified surgical pathologists and surgical	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
		pathology subspecialists associated with those laboratories to whom physicians may refer surgical pathology specimens or slides for consultation; and (2) allow clinicians in the plans access to qualified surgical pathologists and surgical pathology subspecialists for covered pathology services, when the plans do not have contracts with a specific laboratory or laboratories for such services or when the plan's contracted laboratory or laboratories cannot provide the appropriate surgical pathology services. Citation: (Res. 716, A-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 23, A-09)	
H-30.977	Alcoholism as a Disease	The AMA urges change in federal laws and regulations to require that the Veterans Administration determine benefits eligibility on the basis that alcoholism is a disease. Citation: (Res. 112, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-315.986	Confidentiality of Patient Records	Our AMA opposes the concept that filing a claim for medical insurance coverage constitutes a blanket waiver of a patient's right to confidentiality of his/her medical records for all purposes. The AMA will engage in a major initiative to educate patients about the implications and consequences of blanket medical records releases, and educate patients about the need for possible legislative modifications. Citation: (Res. 243, I-94; Appended: Res 231, I-97; Reaffirmation I-98; Reaffirmation I-99; Reaffirmed: CEJA Rep. 8, A-09)	Retain. This policy remains relevant.
H-330.986	Physician ("Doctors") Services Costs as Reported by HHS and Medicare	Our AMA urges HHS and CMS to, at all times, distinguish between MDs/DOs and non-MDs/DOs, and to discontinue the use of the broad term "provider" when reporting or referring to the cost of physician services. Citation: (Res. 71, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-99; Reaffirmation A-02; Reaffirmation I-09)	Retain. This policy remains relevant.
H-335.991	Medical Necessity Denial Screens	Our AMA supports pursuing all available means to effect release of the data necessary for physicians to comply with the onerous provisions of the Medical Necessity Denial/Refund law.	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
		Citation: (Res. 272, A-89; Reaffirmed: Res. 239, A-99; Reaffirmed: BOT Rep. 23, A-09)	
H-340.898	Medicare Review Activities~~: Peer Review Organization Sixth Scope of Work, Medicare Integrity Program, and Carrier Post-Payment Audit Processes~~	Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input ~~in~~ on the ~~development of~~ Medicare Integrity Program ~~task orders before they are implemented~~; (2) continues to oppose any type of "bounty" system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies; (3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing any Medicare review contractor's activities ~~the Medicare Peer Review Organization (PRO) Sixth Scope of Work, especially the Payment Error Prevention Program,~~ and the need to emphasize physician education and clinical improvements; (4) urges CMS to delete all "incentives" or other "award fees" for any Medicare review contractor ~~from the Payment Error Prevention Program in the Medicare PRO Sixth Scope of Work~~; and (5) urges CMS to clarify that in any Statement of Work or contract with a Medicare review contractor ~~the PRO Sixth Scope of Work~~ that: (a) extrapolation should not occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of ~~the~~ Inspector General should not occur unless a hospital does not respond to intervention or when significant evidence of fraud exists. Citation: (CMS Rep. 11, A-99; Reaffirmed: CMS Rep. 14, I-99; Reaffirmed: CMS Rep. 5, A-09)	Retain in part. This policy remains relevant; but modify terms to reflect the current practices of CMS regarding contractor review activities. For example, the Sixth Scope of Work referenced in this policy was finalized in 1999. The original policy was written prior to Medicare Administrative Contractors or Recovery Audit Contractors.

Policy Number	Title	Text	Recommendation
H-340.928	Quality Improvement Organization Physician Advisory Confidentiality	The AMA petitions third party payers and CMS (1) to require QIOs and carriers to publish and forward annually to the quality assurance chairman and the chief of staff of all hospitals under their jurisdictions as well as all state medical associations, the names of physician reviewers, their credentials, and their specialties, and (2) to require that the physician reviewers reveal their identity by signing the letter submitted to a physician placed under review. Citation: (Sub. Res. 200, A-91; Reaffirmation A-99; Modified and Reaffirmed: CMS Rep. 5, A-09)	Retain. This policy remains relevant.
H-345.989	Psychologist Prescribing	The AMA: (1) opposes the prescribing of medication by psychologists; (2) strongly urges through mail and electronic communications technology that all state medical societies work closely with local psychiatric societies to oppose legislative or ballot initiatives authorizing the prescribing of medications by psychologists; and (3) supports and will work in concert with the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and with state and other appropriate medical societies in order to defeat initiatives that authorize psychologist prescribing prescription medication.. Citation: (Sub. Res. 214, A-89; Res. 204, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, A-09)	Retain. This policy remains relevant.
H-35.969	Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio	Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness. Citation: (BOT Rep. 28, A-09)	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-35.976	Channeling of Eye Examinations to Optometrists	The AMA ~~issue a letter~~ advocates to all third party payers ~~stating~~ organized medicine's strong opposition to: (a) channeling enrollees to optometrists and other non-physicians; (b) designating optometrists as primary eye care providers; (c) shifting patients from ophthalmologists to optometrists; and (d) excluding ophthalmologists from performing refractive eye examinations, routine eye examinations, or primary eye care. The AMA, state medical societies, and national medical specialty societies seek introduction of legislation prohibiting third party payers from mandating that routine and refractive examinations be performed by optometrists rather than by ophthalmologists. Citation: (Res. 213, A-98; Reaffirmed: BOT Rep. 23, A-09)	Retain in part. The reference to the letter is no longer relevant.
H-360.985	Performance of Diagnostic X-Rays by Nurses Without Physician Supervision	Our AMA continues to vigorously oppose rules by CMS which lower the standard of training required for performance of diagnostic x-ray or other complex and potentially hazardous tests. Citation: (Res. 201, I-99; Reaffirmed: CMS Rep. 5, A-09)	Retain. This policy remains relevant.
H-383.991	Right to Privately Contract	Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. Citation: (Res. 203, A-09)	Retain. This policy remains relevant.
H-385.969	Assistants at Surgery	The AMA (1) opposes any effort by Medicare or any other third party payer to limit payment for medically necessary care, especially in the area of assistants at surgery; (2) supports and participates in, as appropriate, the efforts of state and specialty societies to develop guidelines for	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
		appropriate use of physicians as assistants at surgery; and (3) continues to oppose and seek regulatory and/or legislative relief from the discriminatory downgrading or elimination of Medicare payments for assistants at surgery. Citation: (Sub. Res. 229, A-91; Reaffirmed: BOT Rep. 32, A-99; Reaffirmed: CMS Rep. 5, A-09)	
H-405.967	Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings	The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory. Citation: (Sub. Res. 4, I-95; Reaffirmed with change in title: CLRPD Rep. 1, A-05; Reaffirmation I-09)	Retain. This policy remains relevant.
H-405.968	Clarification of the Term "Provider" in Advertising, Contracts and Other Communi-cations	1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform. 2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs. Citation: (Sub. Res. 712, I-94; Reaffirmed: Res. 226, I-98; Reaffirmation I-99; Res. 605, A-09; Reaffirmed: CLRPD Rep. 1, A-09; Modified: Speakers Rep., A-15)	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-405.997	Physician-Patient Relationship	Our AMA: (1) believes the terms "physician" and "patient" should be used rather than vendor, provider, recipient or consumer in order to maintain optimum physician-patient relationships and will do so in its medical publications; and (2) encourages third parties, including the U.S. Department of Health and Human Services and federal and state legislative bodies, to use the terms "physician" and "patient" where appropriate in actions, statements and reports. Citation: (Res. 9, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sub. Res. 102, I-94; Reaffirmation I-99; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-09)	Retain. This policy remains relevant.
H-406.990	Work of the Task Force on the Release of Physician Data	Release of Claims and Payment Data from Governmental Programs The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments. Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution. Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare	Retain. This policy remains relevant. [Note: grammatical correction—delete the word "the" before the word "their" in the last sentence.]

Policy Number	Title	Text	Recommendation
		and Medicaid programs should only be released: 1, when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations; 2. upon request of physicians [or their practice entities] to the extent the data involve services that they have provided; 3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation; 4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities]; 5. to other entities only if the data do not identify specific physicians [or their practice entities]; or 6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria: (a) the publication or release of this information is deemed imperative to safeguard the public welfare; (b) the raw data regarding physician claims from governmental healthcare programs is: (i) published in conjunction with appropriate disclosures and/or explanatory	

Policy Number	Title	Text	Recommendation
		statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors. (ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data. (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following: (i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified. (ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the AMA-convened Physician Consortium for Performance Improvement. (iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians. (d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and	

Policy Number	Title	Text	Recommendation
		any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to ~~the~~ their use, publication or release. Citation: (BOT Rep. 18, A-09)	
H-415.98	Informed Choice for Patients	Our AMA in order to protect patient choice of health care providers, supports state and federal legislation mandating that patients be notified of who will provide their medical care, and be given the choice of who will provide their medical care. Citation: (Res. 215, A-98; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-435.947	Liability Reform in Health Care Reform	Our American Medical Association: (1) supports that best clinical practice guidelines represent a medical guideline not a legal one and recognize and encourage that such guidelines do not supplant clinical judgment and that failure to follow each and every clinical guideline should not be used to create a presumption of negligence; and (2) will strongly advocate for clarification in any legislation or regulation relating to risk management, utilization review, and/or cost containment to ensure that any provision does not lead to new theories of liability, such as presumption of negligence in cases of hospital acquired conditions, or inadvertently create new legal causes of action against physicians. Citation: (Res. 206, I-09)	Retain. This policy remains relevant.
H-435.961	Prohibition of Forum Shopping	Our AMA will continue to support laws which limit a plaintiff's right to sue to the state of the defendant's residence or the state where at least a substantial element of the alleged professional negligence arose. Citation: (BOT Rep. 8, I-98; Reaffirmed: BOT Rep. 23, A-09)	Retain. This policy remains relevant.
H-450.955	Education of the General Public on the Role of Physician and Non-Physician Health Care Providers	The AMA will educate the general public and legislators to the differences between physician and non-physician providers of clinical services regarding their unique training, experience, broad based knowledge, ability and expertise, which impacts on their ability to provide high quality clinical care. Citation: (Res. 308, A-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, A-09)	Retain. This policy remains relevant.

Policy Number	Title	Text	Recommendation
H-485.991	Identification of Physicians by the Media	It is the policy of our AMA to communicate to the media that when a physician is interviewed or provides commentary he or she be specifically identified with the appropriate initials “MD” or “DO” after his or her name; and that others be identified with the appropriate degrees after their names. Citation: (Res. 601, I-01; Reaffirmation I-09)	Retain. This policy remains relevant.
H-65.972	Repeal of “Don’t Ask, Don’t Tell”	Our American Medical Association will advocate for repeal of “Don’t Ask, Don’t Tell,” the common term for the policy regarding gay and lesbian individuals serving openly in the U.S. military as mandated by federal law Pub.L. 103-160 and codified at 10 U.S.C. 654, the title of which is “Policy concerning homosexuality in the armed forces.” Citation: (Sub. Res. 917, I-09; BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09)	Rescind. This policy is no longer relevant as the “Don’t Ask, Don’t Tell” Policy is no longer in effect since the law was repealed in 2010.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-19

Subject:	Reforming the Orphan Drug Act (Resolution 217-A-18) An Optional National Prescription Drug Formulary (Resolution 227-A-18) Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (Resolution 238-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

At the 2018 Annual Meeting, the American Medical Association's (AMA) House of Delegates (HOD) referred three resolutions for a combined Board of Trustees (BOT) Report (Report) at the 2019 Annual Meeting. The first resolution, Resolution 217-A-18, "Reforming the Orphan Drug Act," was introduced by the Medical Student Section and asks that:

> Our AMA: (1) support efforts to reform the Orphan Drug Act (ODA) by closing loopholes identified by the Food and Drug Administration [(FDA)]in order to protect the Act's original intent of promoting therapies targeting rare diseases; (2) support increased transparency in development costs, post-approval regulation and overall earnings for pharmaceuticals designated as "Orphan Drugs" and (3)support modifications to the exclusivity period of "Orphan Drugs" to increase access to these pharmaceutical drugs for patients with rare diseases.

The second resolution, Resolution 227-A-18, "An Optional National Prescription Drug Formulary," was introduced by the Florida Delegation and asks that:

> Our AMA: (1) develop a set of principles for a National Prescription Drug Formulary (NPD Formulary) that are designed to lower prescription drug prices to the patient, and be transparent, independent, non-profit, and fee-based, with a report back to the AMA HOD at the 2018 Interim Meeting; (2) produce model legislation for an NPD Formulary with input from appropriate stakeholders based on a set of principles for such a Formulary that the AMA will develop; and (3) that our AMA join with appropriate stakeholders to advocate that Congress authorize the establishment of this NPD Formulary that will be available to all Americans as an option to their healthcare insurance program in an actuarially appropriate manner.

The third resolution, Resolution 238-A-18, "Reform of Pharmaceutical Pricing: Negotiated Payment Schedules," was introduced by the Illinois Delegation and asks that:

> Our AMA: (1) support federal legislation that modifies the Hatch-Waxman Act and the Biologics Price Competition and Innovation Act (Biosimilars Act) to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite

exclusivity for U.S. Food and Drug Administration-approved drugs in the Medicare Part D Program.

The reference committee heard varying testimony on Resolutions 217, 227, and 238. There was testimony providing strong support for the current strategic focus of AMA advocacy and initiatives to increase market competition as well as increased transparency of cost and price along the pharmaceutical supply chain. There was testimony in response to Resolution 217 noting that incentives are needed to support innovation in drug development for rare diseases and general support for the intent of the ODA, but there was concern that manufacturers are manipulating ODA exclusivities and may be driving higher drug costs to vulnerable patient populations. The reference committee heard testimony on Resolution 227 that a new national not-for-profit pharmaceutical benefit manager (which is referred to in the resolution as a national formulary) would not necessarily promote innovation and competition and could substantially limit patient access to medically necessary options. The reference committee heard testimony on Resolution 238 that it did not accurately identify the federal laws that would have to be amended in order to institute the replacement of time-specific patent protections with negotiated payment schedules and indefinite exclusivity for FDA-approved drugs in the Medicare Part D benefit prescription drug program. Testimony was offered noting it would require marked changes to the U.S. Patent Act, the U.S. Food, Drug, and Cosmetic Act (FDCA), and the Social Security Act (SSA). Furthermore, testimony was offered that such changes could limit patient access to clinically necessary alternative options and depress innovation while interjecting significant confusion and complexity in the patent system and the FDA regulatory regime. The reference committee found that all three resolutions are either a potentially complex solution to address the high cost of prescription drugs, or too narrowly crafted. Given these concerns, the reference committee recommended referral for a consolidated report.

AMA STRATEGIC FOCUS: INCREASING TRANSPARENCY AND COMPETITION

The varied contributing causes fueling the rise in prescription medication prices and the proliferation in barriers faced by patients who need medically necessary medication have resulted in the HOD adopting a wide-range of policies concerning prescription medication affordability and access. In order to prioritize impactful and viable policies that would enable the AMA to effectively advocate at the federal and state levels, Policy H-110.987, “Pharmaceutical Costs,” adopted in 2015 directed the AMA to convene a task force of appropriate AMA Councils, state medical societies, and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. Accordingly, the AMA convened a Task Force on Pharmaceutical Costs, which met four times in the first six months of 2016 to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency among pharmaceutical companies, health plans, and pharmacy benefit managers (PBMs) should be the initial focus of the campaign, which led to the launch of a grassroots campaign in the third quarter of 2016, and the launch of the TruthinRx website, TruthinRx.org, on November 1, 2016. The foregoing was done in concert with the AMA’s long-standing advocacy to increase competition. Based on the foregoing the AMA has vigorously supported the focus of policymakers at the federal and state levels to address pharmaceutical supply chain transparency and accelerated and expanded legislative and regulatory action to increase pharmaceutical market competition by, among other things, combating anti-competitive practices.

Increase Pharmaceutical Market Competition and Combat Anticompetitive Practices

Policymakers have increased scrutiny of laws enacted to ensure drug safety and efficacy and to promote innovation that have been manipulated by pharmaceutical manufacturers to delay or block competition. Building off policy raising concerns with anti-competitive practices, the AMA has focused on increasing the authorities and resources of the Federal Trade Commission (FTC) to combat anti-competitive actions of manufacturers as well as changes to the FDA's oversight of the FDCA provisions that have been misused by manufacturers to delay the entry of more affordable generics as outlined below. In addition, the AMA has urged changes to the U.S. Patent Act that are inviting misuse for anti-competitive reasons by manufacturers.

Consistent with long-standing advocacy, the AMA continues to support the FTC's actions to stop pay-for-delay settlements, whereby a brand-name pharmaceutical manufacturer pays a potential generic competitor to abandon its challenge and delay offering a generic drug product for a number of years, for anti-competitive purposes. The AMA is also urging the FTC and Congress to evaluate certain uses of U.S. Patent Act and market exclusivities conferred under the FDCA by pharmaceutical companies that appear primarily designed to increase litigation costs for generic manufacturers and delay market competition. The AMA is also urging more rigorous FTC evaluation of mergers and consolidations among pharmaceutical companies and their impact on competition as well as consumer access by, among other things, expanding clinical expertise within the FTC and consulting with the relevant national medical specialty societies. The AMA is also expressing strong support of enforcement action referrals by the FTC against manufacturers that engage in anticompetitive actions to the U.S. Department of Justice.

In addition, the AMA continues to support measures to address the misuse of FDCA provisions for anti-competitive purposes. The AMA continues to urge Congress and federal agencies to take action to: (1) end the ability of generic manufacturers to indefinitely "park" the 180-day exclusivity period authorized by the FDCA by delaying final approval of their application by the FDA as part of a settlement agreement with a brand manufacturer; (2) further expand the ability of the FDA to address anticompetitive abuse of risk evaluation and mitigation strategies by brand manufacturers—particularly voluntary elements to assure safe use that involve proprietary measures that pose barriers to use by generic competitors; (3) make necessary amendments to the U.S. Patent Act and the FDCA to prevent the inappropriate extension of the exclusivity and patent life of pharmaceuticals. The AMA also strongly supports passage of legislation to increase competition and thus access to some of the most-costly prescription medications: biologicals. The AMA supported the original legislation establishing the follow-on biological pathway and it is now evident that there is a need to shorten the exclusivity period for biological products in order to spur competition which will not decrease the impetus to innovate.

Require Pharmaceutical Supply Chain Transparency

The second component of AMA advocacy has been to encourage transparency throughout the pharmaceutical supply chain. The ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by the often byzantine and confidential arrangements that are driving increased medication prices without a clear and justifiable reason. The practices and policies of pharmaceutical manufacturers, pharmacy benefit managers (PBMs), and health insurers warrant steps by Congress to interject much needed transparency. To that end the AMA strongly supports: (1) requiring pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10 percent or more each year or per course of treatment and provide justification for the price increase; (2) requiring pharmaceutical

manufacturers to publicly disclose a variety of information, which could include research and development costs, expenditures on clinical trials, total costs incurred in production, and marketing and advertising costs; (3) requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices; (4) requiring insurers to provide increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections; and (5) prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons.

AMA POLICY

The AMA has extensive policy relevant to the issues raised in all three resolutions. In general, the AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services (Policy H-155.962, "Maximum Allowable Cost of Prescription Medications").[1] The AMA has adopted comprehensive policy to address anti-competitive measures by manufacturers and to promote increased cost and price transparency (Policy H-110-987, "Pharmaceutical Costs"). AMA policy provides support for action by federal agencies to address manufacturer price gouging. AMA policy also outlines support for the FTC in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and federal legislation to expand the FTC's existing authorities to stop such arrangements (Policy H-110.989, "Pay for Delay Arrangement by Pharmaceutical Companies"). The AMA also supports FDA implementation of the biosimilar pathway established under the Biologics Price Competition and Innovation Act of 2009 in order to ensure patient access, protect patient safety, and preserve market competition and innovation (Policy H-125.980, "Abbreviated Pathway for Biosimilar Approval").

In support of driving increased competition, AMA policy provides for ongoing evaluation of strategies by manufacturers to extend the patent life of pharmaceuticals, and to work with Congress and the Administration where such actions are pursued for anti-competitive purposes (Policy D-110.994, "Inappropriate Extension of Patent Life of Pharmaceuticals"). The AMA also continues to advocate that the FDA and Congress ascertain the pervasiveness of brand manufacturers forcing switching from an established drug formulation about to lose market exclusivity and patent protection to another formulation that retains such protections. This practice is called evergreening and AMA policy provides that a balance must be struck between incentivizing innovation (superior formulations) versus anti-competitive practices designed to slow generic competition (Policy H-125.978, "Patient Protection from Forced Switching of Patent-Protected Drugs"). AMA policy also provides that physicians who develop medical innovations may ethically patent their discoveries or products but should uphold the following guidelines: (a) Not use patents (or other means, such as trade secrets or confidentiality agreements) to limit the availability of medical innovations and patent protection should not hinder the goal of achieving better medical treatments and technologies; and (b) Not allow patents to languish and physicians who hold patents should negotiate and structure licensing agreements in such a way as to encourage the development of better medical technology (Policy H-110.988, "7.2.3 Patents & Dissemination of Research Products").

The AMA supports collaboration with federal and state agencies, policymakers and key stakeholders (e.g., the FTC, FDA, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs (Policy H-110.988, "Controlling the Skyrocketing Costs of Generic Prescription

Drugs"). The same policy provides that the AMA will also seek to advance with interested parties legislation to ensure fair and appropriate pricing of generic medications. The policy also provides that the AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs and the AMA supports measures that increase price transparency for generic prescription drugs.

The AMA has policy to support programs that are designed to contain the rising costs of prescription drugs, provided that physicians have significant input into the development and maintenance of such programs and such programs must encourage optimum prescribing practices and quality of care (Policy H-110.997, "Cost of Prescription Drugs"). Furthermore, under this AMA policy all patients must have access to all prescription drugs necessary to treat their illnesses and physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and the freedom to use either generic or brand name pharmaceuticals in prescribing drugs for their patients. In addition, AMA policy provides support for consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited and reaffirms support for physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients. Finally, the AMA policy provides support for a managed pharmaceutical benefit option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA policies and standards defined in AMA Policy H-125.991 (Policy H-100.964, "Drug Issues in Health System Reform").

The AMA also has a growing body of policy concerning PBMs given growing concerns with their role on patient costs. Policy adopted last year provides that the AMA will gather more data on the erosion of physician-led medication therapy management in order to assess the impact PBM tactics may have on patients' timely access to medications, patient outcomes, and the physician-patient relationship (Policy D-120.933, "Pharmacy Benefit Managers Impact on Patients"). In addition, the same AMA policy provides for an examination of PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts. AMA policy further provides that physicians should report to the FDA MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates precipitated by PBM actions (Policy H-125.986, "Pharmaceutical Benefits Management Companies"). The policy provides support for increased oversight by the FTC to assess the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate where there are indicia of anti-trust and anti-competitive practices. Further, AMA policy provides that certain actions/activities by PBMs and others constitute the practice of medicine without a license and interfere with appropriate medical care to patients. The policy also outlines support for effort to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medication.

DISCUSSION

The AMA is engaged in a comprehensive advocacy campaign at the state and federal level to advance legislation and agency action to increase patient access to affordable prescription medication by increasing market competition and increasing price and cost transparency along the pharmaceutical supply chain. Two of the resolutions and associated resolves would materially depart from this strategy and existing policy. The two resolutions are Resolution 227-A-18, which would involve a major initiative to advance the creation of a not-for-profit PBM fashioned as a national formulary, and Resolution 238-A-18, which would require substantial changes to the

U.S. Patent Act, the FDCA (to alter FDA conferred market exclusivities) and the Social Security Act (to alter relevant Medicare Part D drug benefit provisions). In the case of Resolution 227-A-18, the lack of transparency among the existing commercial PBMs hampers any effort to assess the true value of PBMs in driving affordable pricing and there are widespread concerns, as demonstrated by AMA policies summarized above, that PBM practices have negatively impacted medical practice and patient access to the most appropriate treatment options.

Continued efforts to increase transparency are gaining support from the Trump Administration and Congress. Diverting current AMA efforts to shine a light on PBM practices in order to instead advocate for the creation of a not-for-profit version would be hindered by a lack of information on the measures and mechanisms used by PBMs. Similarly, adoption of Resolution 238-A-18 would represent support for government-imposed price controls in the Medicare program and involve massive disruptions to established patent law and alterations to FDCA conferred exclusivities without addressing drug prices in the commercial market as the resolve calls for government negotiated prices for Medicare Part D drugs, but makes no mention of the commercial market. It would be expected many brand manufacturers would increase prices in the commercial market to offset lower payments in the Medicare program. This would be successful as under this proposed policy, brand manufacturers would not have generic competition as they would receive "indefinite" FDCA exclusivities per the resolve. Perversely, if adopted as policy Resolution 238-A-18 would drive rapid escalation of drug prices in all commercial markets.

Finally, for the most part, AMA policy already addresses Resolution 217-A-18. There are legitimate concerns that the ODA exclusivities[2] have been misused by manufacturers.[3] In November 2018, the Government Accountability Office (GAO) issued a report, Orphan Drugs: FDA Could Improve Designation Review Consistency; Rare Disease Drug Development Challenges Continue. The GAO found that FDA reviewers evaluating a manufacturer's application seeking orphan drug status were not consistently recording or evaluating the required background information needed to assess the appropriateness of the designation. For example, 48 of 148 cases reviewed by the GAO were missing information on the drug's U.S. marketing history. The GAO concluded that the FDA could not be sure that reviewers are conducting complete evaluations that include all critical information needed for assessing its criteria. The FDA has indicated that steps will be taken to ensure such information is included and evaluated. While such steps are meaningful, reportedly, by 2024, orphan drugs are projected to capture a fifth of worldwide prescription drug sales ($262 billion) and the compound annual growth rate is forecasted to grow by 11.3 percent, which is double the rate forecast for the non-orphan drug market. Thus, continued scrutiny is warranted of how ODA exclusivities are conferred and careful consideration to the impact on market competition will remain essential.

RECOMMENDATIONS

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolutions 217-A-18, 227-A-18, and 238-A-18, and the remainder of this report be filed.

1. That our AMA reaffirm Policy H-110.987, "Pharmaceutical Costs," which outlines a series of measures to address anti-competitive actions by pharmaceutical manufacturers as well as policies to promote increased transparency along the pharmaceutical supply chain including among PBMs. (Reaffirm HOD Policy)

2. That our AMA support legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. (New HOD Policy)

Fiscal Note: Less than $500

NOTES

[1] While the AMA has policy that provides support for federal legislation which would confer the Secretary of the Department of Health and Human Services (HHS) with the authority to negotiate contracts with manufacturers for covered Medicare Part D prescription drugs, and provides that the AMA will work toward eliminating Medicare prohibition on drug price negotiation (Policy D-330.954), the taskforce prioritized strategies to increase transparency and to combat the pervasive anti-competitive practices by pharmaceutical manufacturers that are blocking or delaying lower cost, affordable alternative options.

[2] An orphan drug is a prescription medication that treats a rare condition or disease affecting fewer than 200,000 nationwide. The development of orphan drugs has been financially incentivized by the market exclusivities provided under FDCA as amended by the ODA as well as tax credits on research and development, grants for phase I and II clinical trials, and, in some cases, waiver of FDA user fees.
[3] In 2017, it was reported that 70, out of 450, prescription medications with orphan drug status were first approved by the FDA for mass-market use. Early in 2017, Senators Orrin Hatch (R-UT), Charles Grassley (R-IA) and Tom Cotton (R-AR) requested that the U.S. Government Accountability Office (GAO) evaluate the performance of the FDA's Office of Orphan Products Development (OOPD) and to identify "any regulatory or legislative changes may be needed in order to preserve the intent of this vital law." Later in 2017, the new FDA Commissioner urged Congress to implement two new ODA requirements in order to curb abuses of the ODA. Tribble S.J., Lupkin S., Drugmakers Manipulate Orphan Drug Rule to Create Prized Monopolies, Kaiser Health New, January 17, 2017.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-19

Subject: Ban on Medicare Advantage "No Cause" Network Terminations

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-285.961, "Ban on Medicare Advantage 'No Cause' Network Terminations," with a progress report back at the 2019 Annual Meeting. This policy asks that:

> Our American Medical Association (AMA) develop a set of reform proposals addressing the way that Medicare Advantage plans develop and modify their physician networks with the aim of improving the stability of networks, the ability of patients to obtain needed primary and specialty care from in-network physicians, physician satisfaction, and communication with patients about network access with report back to the House of Delegates at the 2019 Annual Meeting.

This report provides background on the issues involved in Medicare Advantage (MA) physician networks and concerns that physicians have raised about the ways that plans form and manage these networks, as well as their communications with patients about their networks. The report recommends that the AMA adopt a set of reform proposals and advocate their adoption. The HOD also reaffirmed existing AMA Policies D-285.998, "Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans," which it further strengthened, Policy H-285.908, "Network Adequacy," and Policy H-285.991, "Qualifications and Credentialing of Physicians Involved in Managed Care," which directly dealt with termination issues as part of the overall action and consideration of this whole issue.

BACKGROUND

MA plans are health insurance plans offered to people with Medicare by private companies that contract with the Medicare program. MA plans must provide all Medicare Parts A and B benefits, they may provide Part D prescription drug coverage, and they often offer extra benefits that traditional Medicare does not cover, such as vision, hearing and dental care coverage. In 2018, over 20 million Medicare beneficiaries, or 34 percent, were enrolled in MA. The Congressional Budget Office estimates that MA enrollment will continue expanding its market share with MA plans projected to include about 42 percent of beneficiaries by 2028.[1]

There are relatively few insurers in the MA market, with most MA enrollees in plans operated by UnitedHealthcare, Humana, or BCBS affiliates.[2] On average, seniors have a choice of 21 plans,[3] with up to 40 in some large metropolitan areas and fewer in rural areas.

Narrow Networks

Narrow network plans have become increasingly common in private health insurance markets, including MA. Generally, such plans offer enrollees a narrow set of physicians and hospitals in a geographic area in exchange for lower premiums.[4] Traditional Medicare allows seniors to access any physician or hospital that accepts Medicare patients, but MA access is limited to physicians and hospitals within plan networks. More than one in three MA enrollees are in a narrow physician network, which is defined as less than 30 percent of physicians in the county participating in the plan. Another 43 percent of enrollees are in medium networks, defined as 30 to 69 percent of physicians in the county participating.[5] On average, MA networks include less than half of all physicians in a given county.

Narrow networks give insurers greater leverage to negotiate physician payment rates and to select those providers that the insurer believes deliver high quality of care.[6] However, MA plans state that, because they already pay providers at or near Medicare fee schedule rates, negotiating lower payment rates is not a significant consideration.[7] Instead, they achieve lower total costs by focusing on utilization.

The AMA and other physician groups have raised concerns that narrow physician networks create challenges for patients seeking care and pose potential patient protection issues. Specifically, a narrow network might have shortages of specific specialties, and plans may purposefully understaff specialties to avoid attracting enrollees with expensive pre-existing conditions like cancer and mental illness.[8] Access to psychiatrists is more restricted than other specialties. On average, only 23 percent of psychiatrists in a county participate in MA plans, and 36 percent of plans include less than 10 percent of psychiatrists in their county.[9] Limited access to specialists extends beyond psychiatry to cardiothoracic surgeons, neurosurgeons, radiation oncologists, and others.

Star Ratings

Star ratings are a key reason for forming narrow networks. MA plans' star ratings affect payment and enrollment, and higher star ratings help increase plan revenues.[10] Plans with high star ratings receive bonuses to their benchmarks and payments from the Centers for Medicare & Medicaid Services (CMS). Total bonuses paid to MA plans have more than doubled over the last four years from $3 billion to $6.3 billion,[11] due to increases in MA enrollment and in the number of plans receiving bonuses. Importantly, MA plans with five-star ratings can enroll beneficiaries at any time throughout the year, not simply during open enrollment or initial eligibility, which is a competitive advantage.[12]

MA plans rely on physicians to achieve their high star ratings by delivering services such as screening tests and vaccines, managing chronic conditions, and cooperating with the plan. Because plans have broad authority to exclude physicians as long as they meet CMS network adequacy requirements, insurers may form narrow networks around already high-performing physicians that have proven track records of quality and utilization management. CMS data show that five-star ratings have been achieved only by vertically integrated and provider-led narrow networks.[13]

Insurers recognize that risk adjustment is another critical component of star ratings. Narrow networks can limit the number of physicians that plans need to coordinate with and educate about diagnosis coding for risk adjustment, which increases plan revenues by increasing the apparent severity of patient conditions compared to traditional Medicare.[14]

DISCUSSION

To improve the way that MA plans develop and modify their physician networks, the Board offers several policy proposals focused on network directory accuracy, network adequacy, network stability, communications with patients, and establishment of an external advisory group to better inform CMS regarding MA network issues.

Enhance CMS Efforts to Ensure Directory Accuracy

MA plans are required to maintain accurate provider directories on a real-time basis, but they are currently only required to submit provider directories to CMS when the plan first begins operations in an area, and then every three years unless CMS requests a review based on significant terminations of contracts or complaints. Since CMS has begun conducting triennial reviews of directories, it has found significant inaccuracies, which justifies more frequent reviews and more significant penalties. MA plans could reduce the administrative burden on themselves and on physicians if they would use a common system for updating provider directory information, such as the AMA/Lexis-Nexis VerifyHCP system.[15]

The AMA could urge CMS to enhance its efforts to ensure directory accuracy by:

- Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network;
- Auditing directory accuracy more frequently for plans that have had deficiencies;
- Publicly reporting accuracy scores on Medicare Plan Finder;
- Taking enforcement action against plans that fail to maintain complete and accurate directories, or to have a sufficient number of physician practices open and accepting new patients; and
- Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information.

Ensure That CMS Network Adequacy Standards Provide Adequate Access for Beneficiaries and Support Coordinated Care Delivery

Current standards do not assess the extent to which physicians in the network are willing and able to see new patients or the extent to which patients want to use the physicians in the network. If most plan members are receiving services only from a subset of physicians in the network, that subset may not represent the "true" network that is available to patients. Additionally, CMS has not released or sought public comments on the standards for the Minimum Provider Ratios and Maximum Time/Distance. In addition, current adequacy standards are established separately for each specialty and there is no requirement that physicians who work together must all be included. For example, there is a requirement to include at least one hospital which offers cardiac catheterization services and at least one cardiologist, but there is no requirement that the network cardiologist be able to perform cardiac catheterizations or that the network cardiologist has privileges at the network hospital.

Ensure Lists of Contracted Physicians Are Made More Easily Accessible

Finding out whether a patient's physicians are in each plan's network requires going separately to each health plan's website, finding the directory, and searching it. If a patient receives care from multiple physicians, this requires considerable time and effort. The plans are already required to submit their initial list to CMS in an electronic form that includes the physician's National Provider

Identifier (NPI), so it should be feasible to not only make the lists downloadable, but also to link the information in the lists to Physician Compare. There is also currently no simple way for a physician to determine whether they are being accurately reported as in-network by the plans with which they currently contract and as out-of-network by other plans. A physician could use a Physician Compare linkage to find which plans say they have contracts with the physician.

Simplify the Process for Beneficiaries to Compare Network Size and Accessibility

It is difficult for patients to determine which plans will have physicians available nearby if new conditions arise or their existing conditions worsen. It is very difficult to compare plans based on the relative size and specialty structure of their networks.

Measure the Stability of Networks

Patients need to know whether they are likely to need to keep changing physicians if they choose a particular plan. There is currently no way to determine if MA plans tend to have the same physicians in-network each year or their networks change significantly from year-to-year.

Physicians have outlined many concerns with the processes that MA plans use to narrow their networks. Plans often send notices to physicians terminating their participation in the network with no explanation, and they do not take steps to ensure that patients can complete their treatment plan and/or find an in-network physician who can take over their care. The lack of explanation for the change, often referred to as "no cause terminations," also makes it impossible for physicians to successfully challenge plans' decisions. As transitions in care are where many adverse events occur, a more cautious approach with more active management of the transition process and more emphasis on supporting established physician-patient relationships would be a major improvement.

There is another side to this story, though, and there are also medical practices who see great benefit in the move to narrower networks. Participants in accountable care organizations (ACOs), for example, may find that they have better opportunities to appropriately manage care for patients assigned to the ACO if the network is largely comprised of other ACO-participating practices. Other practices may benefit from having a higher volume of patients insured by a particular MA plan, and may find that they have more leverage to negotiate better terms and conditions with the plan because the plan's subscribers cannot easily move to a different, out-of-network practice.

The AMA could urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year:

- Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy;
- Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; and
- Evaluating alternative/additional measures of adequacy.

CMS Needs to Develop an Effective Communication Plan

CMS should create a plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients. Additionally, CMS should update the Medicare Plan Finder Website to ensure the website is user-centered.

Oscar Health Care is a New York-based health insurance company focused on delivering care through telemedicine, health care focused technological interfaces, and transparent claims pricing systems.[16] Recently, the America's Health Insurance Plans (AHIP) highlighted "How Oscar Guides Its Members Through the Health System," noting the ease with which users can enroll. Members can sign-up for health insurance in under 10 minutes using the Oscar-created platform (as opposed to brokers or exchanges), which showed a 30 percent increased probability of matching with a plan that optimizes for expected behavior. In an interview with the Oscar Health Care *Head of Product*, Eddie Segal noted that in building the online platform the company prioritized simplicity, incremental navigation, information reduction, and informed, data-driven design.

User-centered design is an iterative process in which architects of said technology or platform focus on the users and their needs, in each phase of the design process. User-centered design requires the involvement of applicable users throughout this process via a variety of research and design techniques in order to create highly usable and accessible products.

The need for user-centered design has become increasingly important, as more health care professionals and patients are exposed to, rely on, and operate within electronic platforms for information related to treatment and diagnosis, disease management, prescription drug coverage, health insurance, and general health care delivery. In 2006, 80 percent of internet users, or approximately 93 million Americans, searched for a health-related topic online, with 25 percent of that population seeking information regarding health insurance – although that number has likely increased significantly during the past 13 years.[17] Of note, between 2000 and 2013, internet and technology usage among seniors rose from 14 to nearly 60 percent.[18]

Medicare patients continue to report frustration and difficulty comparing plans (both fee-for-service and MA) using the "Medicare Compare" tool. They avoid switching plans due to the complexity surrounding initial set-up and voice concern in accessing their preferred physicians and providers.[19] Further interrogation of the Medicare Plan Finder by the National Council on Aging found that poor plan selection and patient confusion often flows from poorly presented information and outdated, misleading user design.[20] Improved and intuitive user-centered design application can enable and empower patients to successfully shop for Medicare plans that meet both clinical need and financial reality.

The AMA could recommend several policy changes to improve communications with patients about MA plan networks. These could include:

- Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur;
- Post the lists on the Medicare Plan Finder website;
- Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician;
- Expanding the information for each MA plan on Medicare Plan Finder to include number of contracted physicians in each specialty and county, extent to which networks exceed minimum standards in each specialty and county, and percent of physicians in each specialty and county who participate in Medicare that are included in the plan's network;
- Measuring and reporting on the stability of networks; and
- Urging CMS to develop a plan to effectively communicate with patients about network access and any changes to MA networks that may directly or indirectly impact patients.

Process Improvements for Recurring Physician Input Regarding Network Policies

Finally, CMS should initiate a Network Adequacy Task Force to meet twice a year with relevant stakeholders, including practicing physicians, trade associations and specialty societies, to both review current policy and develop new policies to address network adequacy issues.

- The American Medical Association could urge Centers for Medicare & Medicaid Services to create a network adequacy task force in order to obtain ongoing input from physicians on needed improvements.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by:

    a. Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network.
    b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies.
    c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder.
    d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1. civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan.
    e. Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information. (Directive to Take Action)

2. That our AMA urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by:

    a. Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year.
    b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy.
    c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together.
    d. Evaluating alternative/additional measures of adequacy. (Directive to Take Action)

3. That our AMA urge CMS to ensure lists of contracted physicians are made more easily accessible by:

    a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action)
    b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to

simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty and county; and C. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network. (Directive to Take Action)

4. That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action)

5. That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action)

6. That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force. (Directive to Take Action)

7. That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

Fiscal Note: Less than $3,500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-19

Subject:	Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Board of Trustees (BOT) Report 4-I-18, "Increased Use of Body-Worn Cameras by Law Enforcement Officers." The BOT Report 4-I-18 followed referral of Resolution 208-I-17, "Increased Use of Body-Worn Cameras by Law Enforcement Officers," introduced by the Medical Student Section, which asked:

> That our American Medical Association advocate for legislative, administrative, or regulatory measure to expand funding for (1) the purchase of body-worn cameras and (2) training and technical assistance required to implement body-worn camera programs.

The reference committee heard supportive testimony of BOT Report 4-I-18, though many requested further study into issues of confidentiality and privacy when body-worn cameras are taken into patient care areas in health care settings.

This Board report provides background, discussion of body-worn cameras by law enforcement officers, including a discussion of body-worn cameras in health care settings, and a recommendation.

BACKGROUND

Following a number of high-profile incidents involving deadly force used against minorities, law enforcement agencies have increasingly adopted body-worn cameras for their officers. Often affixed to the torso, body-worn cameras are small, wearable audio, video or photographic recording systems that record events in which law enforcement officers are involved. The recordings can be used to demonstrate transparency to the community, to document events and to deter inappropriate, illegal or unethical behavior by both the wearer of the camera and the public.

To date, 34 states and the District of Columbia have enacted laws governing the use of body-worn cameras by law enforcement, though not all law enforcement departments utilize cameras in the same manner.[1] For example, some permit officers to turn off the devices under certain circumstances; others do not. In addition, a 2016 survey of large police departments nationwide found that 95 percent intended to implement or had already implemented a body camera program. According to the survey, 18 percent had fully operational programs.[2]

The cost to law enforcement entities to implement and maintain a body camera program can be ongoing. Implementing a program requires an initial capital outlay to purchase the technology and ancillary equipment; law enforcement agencies must account for continuing operational costs, such as training on use, data storage, software and staff and operational costs required for reviewing the recordings, redacting as necessary, and providing recordings to courts and the public as appropriate. In Washington, DC, for example, the city spent over $1 million outfitting 2,800 officers and expects operating costs to top $2 million per year.[3]

In 2015, the U.S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) awarded $22.5 million in grant assistance to state and local law enforcement departments as part of the Body-Worn Camera Pilot Implementation Program. The Consolidated Appropriations Act, 2018 appropriated $22.5 million for a competitive matching grant program for purchases of body-worn cameras for state, local and tribal law enforcement. The BJA expects to make up to 28 awards for a three-year period, which began on October 1, 2018. State and local funding is also available for body-worn cameras.

DISCUSSION

Predicated on whether the AMA ought to support funding of body camera programs is the question of whether the AMA ought to support the expanded use of body cameras and whether the devices achieve their intended outcomes.

Policing Activity

The underlying theory in support of body-worn cameras is that both officers and members of the community will change their behaviors for the better if their actions are being recorded. Indeed, a large body of research suggests that people act differently when they believe they are being watched. In the context of law enforcement, body-worn cameras are expected to increase self-awareness and thus deter unprofessional, inappropriate and illegal behavior by officers and civilians alike. As law enforcement officers are more likely to use force against minority community members, many hope body-worn cameras will improve policing behavior toward minorities, using force only when warranted and de-escalation tactics have failed.[4,5] In cases where law enforcement officers do use force, body-worn cameras offer contemporaneous evidence of the officers' actions so that improper behavior can be disciplined. Evidence about the impact of cameras on policing activity generally, though not universally, supports this theory.

An early study conducted in the Rialto, California police department found use-of-force incidents declined 58.3 percent over a three-year period after a body camera program was implemented.[6] Importantly, researchers later found that use of force rates were higher in the same Rialto, California police force despite the presence of a camera when officers were allowed discretion to turn off cameras.[7] Another randomized controlled trial conducted between 2014 and 2015 in the Las Vegas Metropolitan Police Department found that officers wearing body cameras were 12.5 percent less likely to be involved in a use of force incident.[8] Similar results were found in Orlando, Florida.[9] In contrast, the largest randomized controlled study to date, conducted in 2015 with the Metropolitan Police Department of the District of Columbia, found no statistically significant difference in the rates of police use of force.[10]

Research has found mixed results about other forms of police activity. In the study conducted in Las Vegas, body camera use was not associated with a change in the number of police-community interactions, but body cameras were associated with a 6.8 percent increase in the number of citations issued and a 5.2 percent increase in the number of events that resulted in an arrest. A 2015

study conducted in Mesa, Arizona found officers wearing a camera were less likely to perform stop-and-frisks and make arrests, but were more likely to give citations and initiate encounters.[11] In Phoenix, Arizona use of body-worn cameras were associated with a 17 percent increase in arrests.[12] However, other studies have found body-worn cameras are associated with slightly lower incidents of arrest.[13]

Community Relations

Changing policing behaviors is not the only way body-worn cameras could provide benefits. Many communities and law enforcement agencies see body cameras as a valuable way to improve policing transparency and community relations. Indeed, in 2015 when DOJ grants were announced, then-US Attorney General Loretta Lynch stated that body-worn cameras hold "tremendous promise for enhancing transparency, promoting accountability, and advancing public safety for law enforcement officers and the communities they serve."[14] Body cameras are lauded as a way for the public to better understand what transpires between law enforcement officers and civilians. Officers may also view body cameras positively, as recordings demonstrate to the community the difficult and dangerous job required of them.

Few studies have taken a comprehensive look at community attitudes toward police after the introduction of body-worn cameras.[15] One such study conducted by the Urban Institute found that body-worn cameras do improve community members' satisfaction with police encounters.[13] Another study found that individuals viewed officers as having greater legitimacy, professionalism and satisfaction, but did not find significant differences between citizens' perceptions of officers depending on whether the officer was wearing a camera.[16]

The evidence is clearer, however, that body-worn cameras are associated with decreased rates of complaints filed against law enforcement officers. For example, one early study found complaints against officers dropped 88 percent following implementation of a body cameras program.[6] In Rialto, California, citizen complaints declined by 60 percent. In the Las Vegas Metropolitan Police, officers wearing body cameras were 14 percent less likely to be the subject of a citizen complaint.[8] In Phoenix, complaints against officers who wore the cameras declined by 23 percent, compared to a 10.6 percent increase among comparison officers.[12] In contrast, research in the District of Columbia found no statistically significant difference in the rates of civilian complaints.

The available evidence does not identify the underlying behavioral changes responsible for the decline in complaint rates, however. It may be that body-worn cameras have the intended effect of changing officer behavior for the better, thus reducing circumstances that warrant citizen complaints. It may be that cameras have a "civilizing" effect on members of the public as well. Some evidence also suggests that frivolous complaints are less likely to be filed when recordings are available.[15]

It is important to note, however, that use of body cameras will not automatically foster greater trust between law enforcement and members of the community and should not be viewed, as one evaluation noted, as a "plug-and-play" solution.[10] Notably, the Urban Institute found body-worn cameras improved community satisfaction to a lesser extent than did procedurally just practices, defined in that study as behaving fairly and acting with empathy.[13]

Privacy Considerations

Though the use of body cameras promises greater transparency of law enforcement behavior and actions, they also present new problems, namely intrusion into the privacy of victims, witnesses

and bystanders. For instance, law enforcement officers frequently enter individuals' homes and in-home recordings would become part of the public record. Similarly, interactions and conversations with victims and witnesses could make those individuals uncomfortable or put those individuals in danger. Heavily policed communities–often minority communities–will be more heavily recorded.

These privacy concerns could be addressed with policies to limit recording during such encounters and by limiting the circumstances under which recordings are made available to the public. The American Civil Liberties Union (ACLU) recommends use of body cameras with significant privacy protections. Officer privacy may also be a concern. Some law enforcement unions have opposed body-worn cameras, arguing that adoption of the technology must be negotiated as part of the collective bargaining agreement.

This report acknowledges the significant privacy concerns raised by the ubiquitous use of body-worn cameras, but notes that questions about when cameras need to be turned on and off, how long to keep footage, when recordings will be made publicly available and other policy details are beyond the expertise of the AMA.

Privacy considerations in the health care setting

Body-worn cameras present a unique threat to privacy in a health care setting when, for example, law enforcement officers enter facilities to interview victims and witnesses or retrieve evidence. Law enforcement agencies are not covered entities under the Health Information Portability and Accountability Act (HIPAA) and do not have the same obligation to prevent the disclosure of patient health information as do health care providers and facilities. Providers and facilities, on the other hand, do have a legal obligation under HIPAA to prevent against third-party recording of individually identifiable health information (e.g., patients' faces).

Few states regulate body-worn camera recordings of medical treatment and the preservation of privacy depends instead on cooperation between law enforcement and health care providers. According to the Leadership Conference on Civil and Human Rights, which created a scorecard of body-worn camera policies across the country, many law enforcement agencies have developed policies and procedures which generally prohibit recordings in health care settings except under certain circumstances. Such policies vary considerably in scope and specificity.

Even when privacy laws and regulations are not implicated, the patient-physician relationship is foremost based on trust and the presence of cameras may interfere with honest communication between a physician and patient, particularly when treatment involves sensitive matters such as sexual activity, substance use and mental health. Policies must ensure that recordings are not permitted when they may interfere in the patient-physician relationship, including during clinical interviews, evaluations and treatments.

Nexus with the AMA's Mission

The AMA does not have policy specifically addressing the use of body-worn cameras among law enforcement. During the debate over Resolution 208 during the 2017 Interim Meeting, the reference committee heard testimony questioning whether this topic is within the scope of the AMA's expertise. This concern is reasonable, as AMA has not historically delved into issues of policing and significant resources would be required to bring the AMA into the public policy debates surrounding community policing efforts. Further, while there are dozens of organizations (the Police Executive Research Forum, Leadership Conference on Civil and Human Rights, ACLU,

etc.) that are actively engaged on this issue, it does not appear that any other major medical associations have emerged as significant stakeholders.

Nevertheless, there is a connection between health and police activity, particularly in terms of minority fatality rates. Research has demonstrated that minority communities are disproportionally subject to police force. Specifically, according to an analysis of FBI statistics, African-Americans account for 31 percent of police-involved shootings, but comprise 13 percent of the U.S. population.[4] African-American males are particularly at risk. According to another analysis, African-American males are three times more likely to be killed by police than non-Hispanic white males.[5]

Research has also shown a correlation between policing and other health outcomes. In particular, a recent study found that police killings of unarmed African-Americans were associated with 1.7 days of poor mental health annually among African-Americans. The findings were seen regardless of whether the individual affected had a personal relationship with the victim or whether the incident was experienced vicariously. In addition, the numbers of police stops, coupled with the level of invasiveness during police encounters, is associated with increased levels of stress and anxiety.[17, 18] African-American men report more anxiety and post-traumatic stress disorder and more morbidity from these psychiatric conditions than Caucasian men.[5] In addition, research of data from the New York Police Department revealed that residents in neighborhoods with higher rates of stop-and-frisks were more likely to be in poor health, measured in terms of high blood pressure, diabetes, asthma and self-rated health.[18] Research on the correlation between health and policing, however, remains sparse and warrants further research.

RELEVANT AMA POLICIES

Existing AMA policy does not address the use or funding of body-worn cameras. However, AMA policy does state that physical or verbal violence between law enforcement officers and the public, particularly within ethnic and racial minority communities, is a social determinant of health and supports research into the public health effects of violent interactions (Policy H-515.955). In addition, Policy H-350.971 instructs the AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health.

Policy adopted during the 2018 Annual Meeting encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. New policy also encourages appropriate stakeholders, including law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.

Additionally, Policy H-145.977 cautions against excessive use of conducted electrical devices (often called Tasers) and recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training and an accountability system for the use of conducted electrical devices. AMA policy recommends research into the health impacts of conducted electrical device use and development of a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to conducted electrical devices.

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase body-worn cameras, training for officers and technical assistance for law enforcement agencies. (Directive to Take Action);

2. That our AMA continue to monitor privacy issues raised by body-worn cameras in health care settings. (Directive to Take Action); and

3. That our AMA recommend that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from the medical community and not interfere with the patient-physician relationship. (Directive to Take Action)

Fiscal Note: Less than $5,000

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-19

Subject:	FDA Conflict of Interest (Resolution 216-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

At the 2018 Annual Meeting of the House of Delegates (HOD), Resolution 216-A-18, "[Food and Drug Administration] FDA Conflict of Interest," was referred for report back at the 2019 Annual Meeting. Resolution 216-A-18, sponsored by the Medical Student Section, asked that:

> Our American Medical Association (AMA) advocate (1) that the Food and Drug Administration [(FDA)] place a greater emphasis on a candidate's conflict of interest when selecting members for advisory committees (New HOD Policy); and (2) for a reduction in conflict of interest waivers granted to Advisory Committee candidates.

There was mixed testimony on Resolution 216 during the reference committee. Testimony was offered that disclosure and transparency into conflicts of interest (COI) are important, but on the other hand challenges may exist to find qualified individuals without COIs. Others offered that the FDA should utilize generally accepted COI policies and should limit waivers of such policies for advisory committees.

FDA AND THE ROLE OF ADVISORY COMMITTEES

The FDA utilizes advisory committees to obtain independent expert advice and recommendations on scientific, technical, and policy matters related to FDA-regulated products. There are 50 advisory committees and panels.[1] The recommendations of advisory committees do not bind the FDA. Although the advisory committees include permanent non-voting members who are FDA employees (typically responsible for administering the meetings), the majority are external experts who are considered special government employees (SGEs) while performing their advisory committee duties. The advisory committees cover a range of products.[2]

The FDA's advisory committees are governed by several federal laws and regulations that: (1) establish standards for convening advisory committees; (2) specify criteria for what constitutes a COI; and (3) outline the requirements for disclosing, assessing, and managing COIs. In addition, the FDA has issued guidance documents interpreting government-wide regulations pertaining to the appearance of COIs as well as guidance related to the public availability of advisor COI disclosures and associated FDA waivers. For the most part, the federal laws, regulations, and guidance are generally the same whether a committee advisor is a permanent federal employee or SGE with some exceptions as outlined below. For over a decade, the FDA and Congress have implemented reforms to the FDA's process for assessing COIs, managing COIs including waivers, and public disclosure.[3] Members of the FDA's advisory committees are subject to Federal COI laws (18 USC section 208) as well as government-wide standards of ethical conduct regulations

(5 CFR section 2635.502). Even where a member has no financial interests that would require the member to refrain from participating in an advisory committee meeting ("recuse") under Federal COI laws, the member may be disqualified from participation under the government-wide Federal regulation at 5 CFR section 2635.502 if the member has interests or relationships that may create the appearance that the member lacks impartiality on the issue before the advisory committee.

As specified in federal law, the FDA has a process for determining whether to grant a waiver for an advisory committee member with an actual financial COI. The FDA also has guidance outlining how the Agency evaluates whether an advisory committee member has potentially disqualifying interests or relationships that fall into the second category of interests: appearance of a COI. (In this latter case, the regulations provide that an authorization to participate would be issued as opposed to issuance of a waiver.) In both cases, the decision to permit voting, permit participation, or recusal will be made by the FDA.

PROHIBITION AGAINST FINANCIAL COI

Unless granted a waiver, a federal employee may not "personally and substantially participate" in an official capacity in any particular matter which, to the employee's knowledge, the employee or a related person or organization (whose interests are imputed to the employee under 18 U.S.C. section 208) has a "financial interest" if the particular matter will have a "direct and predictable effect" on that interest (5 CFR section 2640.103(a)). In this analysis, federal employees includes FDA advisory committee members who are considered SGEs. A financial interest is defined as the potential for gain or loss as a result of governmental action on the particular matter which includes stock options, a salary, job offer, indebtedness, and similar interests (5 CFR section 2640.103(b)). Under this law, the financial interests of other, related persons and organizations (as defined in law and statute)[4] are imputed to the employee and may disqualify an employee to the same extent as the employee's own interests. Under the law, a COI arises when the employee participates in an official matter and there is a direct and predictable link between the matters in which the federal employee participates and the employee's financial interests. The link cannot be contingent and dependent on other events.

Process for Reviewing Financial COIs and Granting Waivers

The FDA reviews financial COI disclosures made by potential advisory committee members and the member's expertise with respect to the specific product or policy to be evaluated at a particular meeting. Each adviser is required to certify to the truth and completeness of any information provided.[5] The Agency can issue a waiver to permit participation despite a current conflict or one that ended during the 12 months preceding a meeting consistent with applicable law. The FDA is required by law to apply different standards to SGEs (who constitute the majority of advisory committee members) and permanent government employees in order to determine if an applicable standard for granting a waiver pursuant to 18 USC section 208 is met.

If the individual is a SGE, the FDA's "determination must be based on a certification that the need for the [SGE's] ... services outweighs the potential for a conflict of interest created by the financial interest involved," (5 CFR section 2640.302). The FDA considers a number of factors, including the type of interest that is creating the disqualification, the relationship of the person whose financial interest is involved to the SGE, the uniqueness of the SGE's qualifications, the difficulty of locating a similarly qualified individual without a disqualifying financial interest, the dollar value of the disqualifying financial interest, and the extent to which the disqualifying financial interest could be affected by the actions of the advisory committee.[6] If the individual is a permanent government employee, the FDA determines whether the member's financial interest is

not so substantial as to be deemed likely to affect the integrity of the services provided by that individual. In making this determination, the FDA considers a number of factors, including the type of financial interest that is creating the disqualification, the relationship of the person whose financial interest is involved to the member, the dollar value of the disqualifying financial interest, the nature and importance of the employee's role in the matter, and the need for the employee's services in the particular matter.[7] FDA guidance provides that a common factor to be considered for both categories of advisory committee members is the "need" for the individual's services. In deciding whether there is a need, the FDA will consider: (1) the uniqueness of the member's qualifications; (2) the difficulty locating similarly qualified individuals without a disqualifying financial interest; (3) the value and utility of the member's expertise to the matter being addressed by the committee; and, (4) the nature and extent of the disqualifying financial interest.

In addition, the FDA must apply one more standard to members serving on drug or biologic advisory committees that provide scientific advice and recommendations regarding a clinical investigation or marketing approval. For these members, the standard for a waiver to permit voting is whether a waiver is "necessary" to afford the committee "essential expertise."[8] Where a financial COI exists, the FDA determines whether the member may: (1) participate as a non-voting member, or (2) not participate in the advisory committee.[9] Individuals with financial COIs are not permitted to vote as a matter of FDA policy. A waiver may not be granted when the member's own scientific work is involved.[10]

The Food and Drug Administration Amendments Act of 2007 included a provision capping the number of COI waivers the FDA could grant in any given year. Subsequently, this cap was rescinded in the Food and Drug Administration Safety and Innovation Act of 2012.[11] A recent analysis of FDA COI waivers found that in fiscal year (FY) 2012, the waiver rate did not exceed one percent and this was less than in earlier years.[12] Additionally, the FDA reports COI waiver rates of less than one percent for FYs 2013, 2014, 2015, and 2016 on its online FDA-TRACK Advisory Committees Dashboard.[13]

Public Disclosure

The FDA publicly discloses[14] on the Agency's website the type, nature, and magnitude of the financial interests of each advisory committee member who has received a waiver under 18 U.S.C. section 208. The FDA also provides the reasons for granting each waiver prior to the advisory committee meeting,[15] including, as appropriate, the public health interest in having the expertise of the member with respect to the particular matter.[16]

APPEARANCE OF A CONFLICT OF INTEREST – PERSONAL AND BUSINESS RELATIONSHIPS

Federal law also contains provisions to help ensure that an employee takes appropriate steps to avoid an appearance of loss of impartiality in the performance of his or her official duties. Under 5 CFR section 2635.502 where an agency employee (including FDA advisory committee members), "knows that a particular matter involving specific parties is likely to have a direct and predictable effect on the financial interest of a member" of the employee's household, or knows that a person with whom the employee has a "covered relationship is or represents a party to such matter," and "where the employee determines that the circumstances would cause a reasonable person with knowledge of the relevant facts" to question the employee's impartiality in the matter, the employee should not participate in the matter unless the employee has informed the agency designee of the appearance problem and received authorization from the agency designee. An employee has a "covered relationship" with:

- a person other than a prospective employer with whom the employee has or seeks a business, contractual or other financial relationship that involves other than a routine consumer transaction;
- a person who is a member of the employee's household, or who is a relative with whom the employee has a close personal relationship;
- a person for whom the employee's spouse, parent or dependent child is, to the employee's knowledge, serving or seeking to serve as an officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee; any person for whom the employee has, within the last year, served as officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee; or
- an organization, other than a political party,[17] in which the employee is an "active participant."[18]

Granting a Section 502 Authorization

If the FDA concludes that an appearance issue exists, a determination is made whether the Agency's interest in the member's participation outweighs the concern that a reasonable person may question the integrity of the Agency's programs and operations. If so, the FDA may grant an authorization (i.e., a waiver) before the meeting to allow the member to participate. The FDA may limit authorization or deny authorization. The Agency takes into consideration a number of factors including, but not limited to: (1) the nature of the relationship involved; (2) the effect that resolution of the matter would have upon the financial interests of the person involved in the relationship; (3) the nature and importance of the member's role in the matter, including the extent to which the member is called upon to exercise discretion in the matter; (4) the sensitivity of the matter; (5) the difficulty of reassigning the matter to another expert; and (6) adjustments that may be made in the member's duties that would reduce or eliminate the likelihood that a reasonable person would question her impartiality.

RESEARCH ON COI AND FDA ADVISORY COMMITTEE RECOMMENDATIONS

Despite long-standing federal laws governing COIs and waivers applicable to FDA advisory committee members, there have remained persistent concerns in the general public that waivers of COIs negatively impact the trustworthiness and independence of advisory committee recommendations. However, the research and investigations into this matter have produced mixed results. In a 2014 study of FDA advisory committee member COIs, a researcher found that, where an advisory committee member had an exclusive financial relationship with the manufacturer (referred to as a sponsor) of the product under review, the member appeared to be biased in support of the product sponsor.[19] No similar bias was found where members had financial ties to both a sponsor and its competitors.[20] The study author noted that "[t]hese findings point to important heterogeneities in financial ties and suggest that policymakers will need to be nuanced in their management of financial relationships of FDA advisory committee members."[21] In another study, the researchers found little significant evidence that advisory committee members vote in their financial interests. [22] The authors also found that the perverse exclusion of "financially-conflicted members resulted in a sharp drop in average member expertise, and an unintended increase in approval voting." The study authors concluded that "[e]liminating conflicts could sharply reduce the level of expertise of the decision makers and lead to unexpected voting tendencies."[23] More recently, an investigation of FDA advisory committee members COIs has called into question: (1) the completeness of COI disclosures submitted by members; (2) whether the FDA does enough to verify the completeness and accuracy of such disclosures; and (3) whether past or current COI assessments are inadequate as pay-later COIs may play a more significant role in influencing a member's deliberations and vote. Specifically, a 2018 investigation found that, at the time of or in

the year leading up to the advisory committee meetings under scrutiny, many of the members received payments or other financial support from the sponsoring drug firm or key competitors for consulting, travel, lectures, or research.[24] The investigators concluded that the FDA did not publicly disclose those ties even though this information was disclosed in scholarly journals.[25] In the same investigation, a review was undertaken of compensation records from drug sponsors to advisory committee members who advised the FDA on whether to approve 28 psychopharmacologic, arthritis, and cardiac or renal drugs between 2008 and 2014.[26] The investigators concluded that there were "widespread after-the-fact payments or research support to panel members."[27] As correctly noted by the investigators: "[t]he agency's safeguards against potential conflicts of interest are not designed to prevent such future financial ties."

AMA POLICY

The AMA has policy addressing COIs applicable to FDA advisory committees (Policy H-100.992, "FDA") as well as ethics policy concerning COIs in the areas of research (Ethics Opinion 7.1.4/ AMA Principles of Medical Ethics: II, IV,V, "Conflicts of Interest in Research") and clinical practice guidelines (Policy H-410.953, "Ethical Considerations in the Development of Clinical Practice Guidelines").

DISCUSSION

The resolved clauses in Resolution 216 would have the AMA adopt policy that specifies that the FDA should place a greater emphasis on advisory committee member COIs and seek a further reduction in the number of COI waivers granted by the FDA. While there is widespread consensus that COI policies are appropriate and necessary along with a measured approach to granting COI waivers for FDA advisory committee members, there is also concern that an overzealous approach to waivers will undermine the actual or perceived quality of advisory committee recommendations. The FDA has reduced the number of waivers granted, but there are conflicting reports with regard to the magnitude of the challenge the Agency faces filling advisory committee vacancies. For example, one article reported that in FY 2017, "218 advisory committee positions of the 600-plus on the FDA's 49 advisory committees had not been filled."[28] Yet, data disclosed by FDA indicates that in FY 2017 there were 64 vacancies out of 564[29] and in FY 2018 there were 57 total vacancies out of 547 members.[30] A 10 percent vacancy is substantially lower than a nearly 50 percent vacancy. Nonetheless, the COI waiver rate has remained consistently below one percent. Lowering this percentage further is reasonably likely to increase vacancies which are hovering at 10 percent.

Existing AMA ethics policy provides a clear set of parameters concerning COIs and waivers regarding clinical practice guidelines development and clinical research that should be utilized to expand upon AMA policy concerning FDA advisory committee member COIs and waivers. Our current AMA policy related to advisory committee members provides that a FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute and evidence of such should be evaluated by the FDA, in consultation with its advisory committees (Policy H-100.992, "FDA"). The policy also provides that the FDA should not let COIs overrule scientific evidence in making policy decisions. Building on the above policy, our AMA has ethics policy noting how minimizing and mitigating COIs in clinical research is imperative to justify and maintain trust in the medical research community (7.1.4, "Conflicts of Interest in Research"). This is equally true for FDA advisory committee member recommendations. This same policy provides that physicians who engage in research should disclose material ties to companies whose products they are investigating or other ties that create real or perceived COIs. Similarly, AMA ethics policy concerning clinical practice

guidelines provides that patients, the public, physicians, and other stakeholders must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable (Policy H-410.953, "Ethical Considerations in the Development of Clinical Practice Guidelines"). Notably, while Policy H-410.953 specifies that published guidelines/updates are to be developed independent of direct financial support from entities that have an interest in the recommendations, it does specify consideration for COIs (actual and perceived) for individuals associated in the development of the guidelines. The policy states: "ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline." In order to ensure credibility, our AMA policy provides that:

> formal procedures would be adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided.

Finally, the policy provides for a clear statement of methodology, COI policy and procedures, and disclosures of panel members' COIs. Extending the foregoing policies to FDA advisory committee member COIs and waivers will underscore the importance of existing FDA laws, regulations, and policies. However, the policy does not address concerns that advisory committee members may not be fully disclosing conflicts and independent targeted auditing for sufficiency may be warranted. In addition, existing policy does not address the impact of pay-later COIs (e.g., where a FDA advisory committee member develops a financial COI only after his or her initial appointment on the advisory committee has expired). Since there is limited research on the topic, this is important area for the FDA and researchers to more fully evaluate and craft appropriate policy.

RECOMMENDATION

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed:

1. That our AMA reaffirm Policy H-100.992, "FDA," which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees. (Reaffirm HOD Policy)

2. That our AMA adopt the following new policy:

   It is the position of the American Medical Association that decisions of the Food and Drug Administration (FDA) must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that FDA decisions and the recommendations of FDA advisory committees are ethically and scientifically credible and derived through a process that is rigorous, independent, transparent, and accountable. Rigorous policies and procedures should be in place to minimize the potential for financial or other interests to influence the process at all key steps. These should include,

but not necessarily be limited to: a) required disclosure of all relevant actual or potential conflicts of interest, both financial and personal; b) a mechanism to independently audit disclosures when warranted; c) clearly defined criteria for identifying and assessing the magnitude and materiality of conflicts of interest; and d) clearly defined processes for preventing or terminating the participation of a conflicted member, and mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when an individual's participation cannot be terminated due to the individual's unique or rare skillset or background that is deemed highly valuable to the process. Further, clear statements of COI policy and procedures, and disclosures of FDA advisory committee members' conflicts of interest relating to specific recommendations, should be published or otherwise made public. Finally, it is recognized that, to the extent feasible in accordance with the principles stated above, participation on advisory committees should be facilitated through appropriate balancing of the relative scarcity or uniqueness of an individual's expertise and ability to contribute to the process, on the one hand, as compared to the feasibility and effectiveness of mitigation measures including those noted above. (New HOD Policy)

3. That our AMA adopt the following new policy:

It is the position of the American Medical Association that the FDA should undertake an evaluation of pay-later conflicts of interest (e.g., where a FDA advisory committee member develops a financial conflict of interest only after his or her initial appointment on the advisory committee has expired) to assess whether these undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] FDA Advisory Committees, Accessed on February 25, 2019
[2] Id. Products include blood, vaccines and other biologics; human drugs; food; medical devices; patient engagement; pediatric; radiation-emitting products; risk communication; science board; toxicological research; veterinary; and tobacco.
[3] See, for example, the FDA Amendments Act (FDAA) of 2007 which mandated that by 2012 no more than thirteen percent of committee advisors per year could receive COI waivers. The FDA reduced the maximum size of financial interests eligible for waivers from a combined financial interest of up to $100,000, to a maximum of $50,000. See also Draft Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining COI and Eligibility for Participation in FDA Advisory Committees (March 2007); Public Availability of Advisory Committee Members' Financial Interest Information and Waivers-Final Guidance (2014); and, Procedures for Evaluating Appearance Issues and Granting Authorizations for Participation in FDA Advisory Committees (2016).
[4] Related persons and organizations include: the employee's spouse, minor child, or general partner; an organization or entity for which the employee serves as officer, director, trustee, general partner, or employee; and a person with whom the employee is negotiating for, or has an arrangement concerning, prospective employment.
[5] In preparation for advisory committee meetings involving particular matters, SGEs invited to participate in the meetings are required to report to FDA any financial interests related to the subject matter of the advisory committee meeting. 5 CFR § 2634.904(a)(2). Permanent government employees also report financial interests on a yearly basis and/or just prior to the advisory committee meeting they are planning to attend. 5 CFR §§ 2634.202 and 2634.904(a)(1). The FDA reviews not only the financial interests of a potential advisory committee participant and the individual's immediate family, but also the financial interests, of which the individual has knowledge, of the participant's business partners, organizations for which the individual serves as officer, director, trustee, general partner, or employee, and any prospective employer of the member (if there are ongoing employment negotiations or an agreement regarding future employment). See 18 U.S.C. § 208(a).
[6] 5 CFR 2640.302(b)
[7] 5 CFR 2640.301(b)
[8] Food, Drug, and Cosmetic Act section 505 (n)(4) "Each member of a panel shall publicly disclose all conflicts of interest that member may have with the work to be undertaken by the panel. No member of a panel may vote on any matter where the member or the immediate family of such member could gain financially from the advice given to the Secretary. The Secretary may grant a waiver of any conflict of interest requirement upon public disclosure of such conflict of interest if such waiver is necessary to afford the panel essential expertise, except that the Secretary may not grant a waiver for a member of a panel when the member's own scientific work is involved."
[9] Draft Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining COI and Eligibility for Participation in FDA Advisory Committees March 2007
[10] Id.
[11] Wood SF, Mador JK. *Science and regulation. Uncapping conflict of interest?* Science (2013)
[12] Lurie P. *Suggestions for Improving Conflict of Interest Processes in the US Food and Drug Administration Advisory Committees—Past Imperfect*. JAMA Intern Med. 2018;178(7):997–998. doi:10.1001/jamainternmed.2018.1324
[13] Report to Congress Food and Drug Administration Safety and Innovation Act, Section 712 (e) of the Federal Food, Drug, and Cosmetic Act, Fiscal Year 2016 Annual Report on FDA Advisory Committee Vacancies and Public Disclosures Accessed on February 27, 2019
[14] The FDA does not publicly disclose financial interest information if it is exempt from disclosure under the Freedom of Information Act or otherwise protected from disclosure by statute or regulation, except if necessary to describe the type, nature, and magnitude of the financial conflict being waived.
[15] This information must be published within specified time frames before advisory committee meetings. Food, Drug, and Cosmetic Act section 712(c).
[16] FDA Guidance on Publication of Financial COI waivers. https://www.fda.gov/RegulatoryInformation/Guidances/ucm391034.htm#_ftn11
[17] Political party as described in 26 U.S.C. 527(e)

[18] Participation is active if, for example, it involves service as an official of the organization or in a capacity similar to that of a committee or subcommittee chairperson or spokesperson, or participation in directing the activities of the organization. In other cases, significant time devoted to promoting specific programs of the organization, including coordination of fundraising efforts, is an indication of active participation. Payment of dues or the donation or solicitation of financial support does not, in itself, constitute active participation.
[19] Pham-Kanter G., Revisiting Financial Conflicts of Interest in FDA Advisory Committees, Milbank Quarterly, September 2014 Volume 92, Issue 3 (pages 446–470), DOI: 10.1111/1468-0009.12073
[20] Id.
[21] Id.
[22] Cooper J., Golec J. Conflicts of Interest on Expert Committees: The Case of FDA Drug Advisory Committees, University of Connecticut School of Business Research Paper No. 17-02, April 2018 Accessed February 24, 2019
[23] Id.
[24] Piller C., You J. Hidden conflicts? Pharma payments to FDA advisers after drug approvals spark ethical concerns, Science Magazine, July 5, 2018 Accessed February 24, 2019
[25] Id.
[26] Id.
[27] Piller C., You J. Hidden conflicts? Pharma payments to FDA advisers after drug approvals spark ethical concerns, Science Magazine, July 5, 2018 Accessed February 24, 2019
[28] Sullivan, T., FDA Conflicts of Interest Rules Means Fewer Experts on Advisory Panels, Policy and Medicine Blog, May 5, 2018 Accessed on February 24, 2019.
[29] FDA website – online Percent of FDA advisory committee member positions vacant at the end of the month Accessed February 27, 2019
[30] FDA website – online Percent of FDA advisory committee member positions vacant at the end of the month Accessed February 27, 2019

APPENDIX: RELEVANT AMA POLICY

Policy H-100.992, "FDA"

(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

7.1.4 Conflicts of Interest in Research

Increasing numbers of physicians, both within and outside academic health centers, are becoming involved in partnerships with industry to conduct biomedical and health research. As they do so, physicians must be mindful of the conflicts such engagement poses to the integrity of the research and the welfare of human participants. In addition to financial conflicts of interest created by

incentives to conduct trials and recruit subjects, physicians must be sensitive to the differing roles of clinician and investigator, which may require them to balance dual commitments to participants and science. This conflict of commitment is particularly acute when a physician-investigator has treated or continues to treat a patient who is eligible to enroll as a participant in a clinical trial the physician is conducting.

Minimizing and mitigating conflicts of interest in clinical research is imperative if the medical community is to justify and maintain trust in the medical research community.

Physicians who engage in research should:

(a) Decline financial compensation that awards in excess of the physician's research efforts and does not reflect fair market value. Physicians should not accept payment solely for referring patients to research studies.

(b) Ensure that the research protocol includes provision for funding participants' medical care in the event of complications associated with the research. A physician should not double-bill a third-party payer for additional expenses related to conducting the trial if he or she has already received funds from a sponsor for those expenses.

(c) As part of the informed consent process, disclose to prospective participants the nature and source of funding and financial incentives offered to the investigators. This disclosure should be included in any written consent materials.

(d) Avoid engaging in any research where there is an understanding that limitations can be placed on the presentation or publication of results by the research sponsor.

(e) Refrain from knowingly participating in a financial relationship with a commercial entity with whom they have a research relationship until the research relationship ends and the research results have been published or otherwise disseminated to the public.

(f) Disclose material ties to companies whose products they are investigating or other ties that create real or perceived conflicts of interest to:

(i) institutions where the research will be carried out;

(ii) organizations that are funding the research;

(iii) any journal or publication where the research results are being submitted.

(g) Physicians who have leadership roles in institutions that conduct biomedical and health research as well as the entities that fund research with human participants should promote the development of guidelines on conflicts of interest that clarify physician-investigators responsibilities.

AMA Principles of Medical Ethics: II,IV,V; The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016

Policy H-410.953, "Ethical Considerations in the Development of Clinical Practice Guidelines"

Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. Clinical practice guidelines help inform physician judgment and decision making by physicians and patients. Clinical practice guidelines also have significant potential to meaningfully inform efforts to provide care of consistently high quality for all patients and to help shape development of sound public policy in health care. To achieve those ends, clinical practice guidelines must be trustworthy. Patients, the public, physicians, other health care professionals and health administrators, and policymakers must have confidence that published guidelines are the ethically and scientifically credible product of development processes that are rigorous, independent, transparent, and accountable.

To that end, the development or updating of clinical practice guidelines should meet the following expectations:

1. Guidelines/updates are developed independent of direct financial support from entities that have an interest in the recommendations to be developed.
2. Formal, scientifically rigorous methods and explicit standards are adopted for the review and weighting of evidence, the integration of expert judgment, and the strength of clinical recommendations.
3. Guideline panels have access to appropriate expertise among members or consultants, including not only relevantly qualified clinical experts but also appropriately qualified methodologists, representatives of key stakeholders, and, ideally, one or more individuals skilled in facilitating groups.
4. Ideally, all individuals associated with guideline development will be free of conflicts of interest during the development process and will remain so for a defined period following the publication of the guideline.
5. Formal procedures are adopted to minimize the potential for financial or other interests to influence the process at all key steps (selection of topic, review of evidence, panel deliberations, development and approval of specific recommendations, and dissemination of final product). These should include: a) required disclosure of all potential conflicts of interest by panel members, consultants, staff, and other participants; b) clearly defined criteria for identifying and assessing the seriousness of conflicts of interest; and c) clearly defined strategies for eliminating or mitigating the influence of identified conflicts of interest (such as prohibiting individuals from participating in deliberations, drafting, or voting on recommendations on which they have conflicts) in those limited circumstances when participation by an individual with a conflicting interest cannot be avoided.
6. Guidelines are subject to rigorous, independent peer review.
7. Clear statements of methodology, COI policy and procedures, and disclosures of panel members' conflicts of interest relating to specific recommendations are published with any guideline or otherwise made public.
8. Guidelines are in the first instance disseminated independent of support from or participation by individuals or entities that have a direct interest in the recommendations.

REPORT 20 OF THE BOARD OF TRUSTEES (A-19)
Safe and Efficient e-Prescribing
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting Policy D-120.972, "Electronic Prescribing," was amended by the House of Delegates (HOD) with additional directives from Resolution 237-A-18. The policy asks the American Medical Association (AMA) to study current electronic prescribing (e-prescribing) processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers. This report provides the requested study of current e-prescribing processes, including benefits and challenges, examples of interventional case studies, opportunities for improvement, and recommendations for multiple stakeholders.

The electronic exchange of prescription and medication history information between prescribers, pharmacies, and payers/pharmacy benefit managers, referred to as e-prescribing, has been shown to improve efficiency, patient safety, and cost savings. E-prescribing has also been shown to reduce medication errors and increase efficiencies in patient care. Despite the numerous advantages of e-prescribing over the former paper prescription systems, there are barriers to the safe and efficient use of e-prescribing systems, suggesting there are opportunities for improvement to maximize efficiency and safety.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-19

Subject: Safe and Efficient e-Prescribing

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting Policy D-120.972, "Electronic Prescribing," was amended by the House of Delegates (HOD) with additional directives from Resolution 237-A-18. The policy asks the American Medical Association (AMA) to study current electronic prescribing (e-prescribing) processes and make recommendations to improve these processes to make them as safe as possible for patients and as efficient as possible for prescribers.

This report provides the requested study of current e-prescribing processes, including benefits and challenges, examples of interventional case studies, and opportunities for improvement.

BACKGROUND

The electronic exchange of prescription and medication history information between prescribers, pharmacies, and payers/pharmacy benefit managers, referred to as e-prescribing, has been shown to improve efficiency, patient safety, and cost savings. E-prescribing has also been shown to reduce medication errors and increase efficiencies in patient care.[1] In 2017 almost 70% of prescribers and 98% of pharmacies were utilizing e-prescribing.[2] Despite vast increases in adoption of e-prescribing and the improvements realized thus far, there are still areas for improvement in e-prescribing. For example, functions of the electronic systems, such as excessive or unnecessary alerts,[1, 3] and the processes required for prescribing controlled substances, are perceived as remaining barriers to the optimal use of e-prescribing.[1] The authors of Resolution 237-A-18 expressed concern that some steps required to order an e-prescription, such as selecting a pharmacy to which the prescription should be filled, are error-prone and not efficient use of physician time. The current two-factor authentication process required to electronically prescribe controlled substances (EPCS) has also been noted as a cumbersome requirement lacking efficiency and contributing to the slower adoption of EPCS compared to non-controlled substances. In 2017 21% of controlled substances were prescribed electronically compared to 90% of non-controlled substances.[4] Despite the numerous advantages of e-prescribing over the former paper prescription systems, the systems and processes still have opportunities for improvement to maximize efficiency and safety.[5]

AMA POLICY

The AMA supports e-prescribing for both controlled and non-controlled substances and has numerous policies expressing its commitment to advocating for better regulations and better systems that enable more efficient, safe, and less burdensome use of e-prescribing. The AMA

supports programs that incentivize adoption of e-prescribing systems, but opposes a funding structure that financially penalizes physicians that have not adopted such technology (Policy H-478.991, "Federal EMR and Electronic Prescribing Incentive Program"). The AMA continues to work with the Centers for Medicare and Medicaid Services (CMS) to ensure that the e-prescribing policies and reporting procedures provide the greatest flexibility to physicians who participate in the program (Policy D-120.957, "Electronic Prescribing Incentive Program"). The AMA encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care (Policy H-95.939, "Development and Promotion of Single National Prescription Drug Monitoring Program").

Recognizing that EPCS continues to pose administrative burdens for physicians, in 2017 the AMA modified existing policy to continue to advocate before federal and state agencies and legislative bodies for elimination of cumbersome, confusing and burdensome requirements relating to electronic transmission of physicians' controlled substance prescriptions to pharmacies," (Policy D-120.956, "Electronic Prescribing and Conflicting Federal Guidelines"). The AMA also supports action requiring that the U.S. Drug Enforcement Administration (DEA) establish reasonable requirements enabling the use of e-prescribing for controlled substances (Policy H-120.941, "e-Prescribing of Scheduled Medications"). In addition, the AMA is committed to reducing federal roadblocks to e-prescribing and is working with the CMS and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs. Through this work the AMA will reduce regulatory burdens to facilitate further adoption of e-prescribing, including for controlled substances (Policy D-120.958, "Federal Roadblocks to E-Prescribing").

The AMA advocates for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner and is committed to working with stakeholders to encourage the use of standards that allow direct physician/pharmacist communication within existing electronic health record (EHR) or e-prescribing systems (Policy D-120.944, "Improvement of Electronic Prescription Software"). The AMA sought from CMS and the DEA a requirement that all pharmacies and Pharmacy Benefits Managers (PBMs) acquire and implement the appropriate electronic prescribing of controlled substances software to accept electronically transmitted controlled substance prescriptions from prescriber systems that comply with CMS and DEA certification requirements (Policy D-120.945, "Completing the Electronic Prescription Loop for Controlled Substances"). The AMA also works with pharmacy benefit managers, payers and pharmacists to make accurate, real-time formulary information available at the point of care. It is AMA's priority to promote procedural policies that ensure changes in formulary information are communicated promptly to prescribers so alternative medication can be provided to patients in a timely manner (Policy H-125.979, "Private Health Insurance Formulary Transparency").

The AMA recognizes the importance of patient safety in the e-prescribing process, and is committed to working with pharmaceutical, e-prescribing and point of care resource stakeholders to increase physician awareness of risk evaluation and mitigation strategies to improve patient safety in the e-prescription process (Policy D-100.971, "Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation"). In addition, the AMA urges Congress to unify state prescription standards to facilitate further adoption of e-prescribing, and supports efforts to amend federal law to allow for the e-prescribing of a medication needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine (Policy D-120.972, "Electronic Prescribing"). Last, in support of efforts to reduce medication errors by increasing efficiency and safety in the process of cancelling electronic prescriptions, the AMA supports the creation,

standardization, and implementation of electronic prescription cancellation from all electronic medical records vendors and that these orders be accepted by pharmacies and pharmacy benefit managers (Policy H-478.983, "Electronic Prescription Cancellation").

DISCUSSION

E-prescribing overview

E-prescribing is the computer-based electronic generation, transmission, and filling of a prescription, that replaces the need for paper and faxed prescriptions. CMS describes e-prescribing as "the ability for a prescriber to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care."[6]

E-prescribing eliminates the need for paper prescriptions, which can create hazards and increase risk of medical errors. E-prescribing systems can reduce medical errors, decrease pharmacy costs, improve both prescriber and pharmacy efficiency, eliminate handwriting interpretation errors, reduce phone calls between pharmacists and physicians, reduce data entry, and expedite prescription refill requests.[7] In addition, e-prescribing can improve efficiencies by introducing an automatic process to reconcile drug-drug interactions and patient allergies at the point of prescribing. E-prescribing platforms also facilitate the ability to monitor prescribing patterns, which can help organizations ensure high-quality and cost-effective care.[8]

Although e-prescribing was not new and many practices had already transitioned from paper to electronic systems, in 2012 CMS implemented the Medicare eRx Incentive Program to encourage electronic prescribing by eligible professionals. The eRx program provided an incentive payment to eligible professionals who successfully e-prescribed for covered Medicare Part B services, and applied payment adjustments to those who did not. The eRx program ended in 2013 and was replaced with the Meaningful Use Incentive Program, which ended in 2017. E-prescribing measurement continues within the Merit Based Incentive Payment System track of the Medicare Quality Payment Program. In addition, CMS requires Medicare Part D sponsors, prescribers, and drug dispensers that transmit prescriptions and prescription-related information electronically to support and comply with the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard when filing prescriptions electronically. CMS will adopt a revised SCRIPT standard on January 1, 2020.[9] The new standard will include support for several functions that aim to improve efficiency, clinical decision-making and patient safety. New functionalities will include support for grouping of multiple prescriptions and the reporting of allergies and adverse events, enhancements to digital signatures, and the choice of whether or not to receive RxFill notifications.[10]

Improvements gained from e-prescribing

With the introduction of EHRs and industry movement to leverage more technology solutions in patient care, e-prescribing has become a key component of the daily clinical workflow. E-prescribing has been shown to provide many benefits in comparison to traditional paper prescribing

A principal benefit of e-prescribing is the improvement in quality of care and patient outcomes. Through e-prescribing, prescription accuracy, standardization and safety have improved.[11] Prescribing through specialized pharmacy software and/or an EHR provides clinical decision support (CDS) tools and screening capabilities that alert prescribers to potential adverse drug interactions or over-prescribing. These improvements have led to a reduction in medical errors, resulting in better patient outcomes and improved quality of care. One study found error rates decreased from 42.5 per 100 prescriptions to 6.6 per 200 prescriptions.[11] It is estimated that

medication errors have been reduced to as little as one-seventh of their previous level as a result of e-prescribing.[1]

The reduction in medical errors and improved quality outcomes have led to significant cost savings to the overall healthcare system. It is estimated that improved patient outcomes and decreased patient visits may result in between $140 billion and $240 billion in cost avoidance over 10 years for practices that implement e-prescribing.[1] E-prescribing also assists with cost savings by reducing fraud, abuse and drug diversion. Through e-prescribing, prescriptions and usage are more effectively tracked, and the elimination of a paper script reduces the risk of fraud and illegal prescription sales. The secure and safe transfer of data and prescriptions to a pharmacy also serves as another protective safe guard in preventing drug diversion, as well as enhanced safety.

In addition, increased efficiency at the practice level has been reported. E-prescribing assists by reducing challenges with legibility problems from handwritten prescriptions.[12] It also saves time for the physician and team by reducing the number of calls received from the pharmacy to clarify prescriptions.[5] Although one study estimated it takes a prescriber 20 seconds longer per patient to complete an e-prescription versus paper, the long-term benefits to the prescriber and patient are overall time savings, costs savings and reduced prescription errors.[11, 13, 14]

E-prescribing has also been shown to improve patient satisfaction. Many patients prefer the ease and quick transmission of prescriptions to their pharmacy as well as the convenience of eliminating paper prescriptions and reduced wait time at the pharmacy. Many platforms are also providing more information on cost-effective medication options based on a patient's particular health plan, leading to cost-savings for the patient and health system.[15]

Despite the potential additional time and steps required for e-prescribing, the impacts to workflow should be minimal if systems are implemented effectively.[1] Most prescribers feel the benefits of e-prescribing outweigh the burdens created by additional steps, and that the extra time spent in the e-prescribing system is offset by the efficiencies gained in the overall process.[1, 5]

The patient safety benefits and efficiencies of e-prescribing can be further enhanced through the use of Structured and Codified Sig (short for Signatura). Structured and Codified Sig is designed to communicate prescription dosing instructions in a codified way to the pharmacy that can then be conveyed to the patient, thus reducing the opportunity for transcription errors and improving efficiencies and work flows for prescribers and pharmacists. Unfortunately, despite its potential benefits, Structured and Codified Sig has neither been widely utilized by prescribers nor supported by EHRs that allow e-prescribing. NCPDP, which develops and maintains the SCRIPT standard, convened a task group to review these utilization and support issues and developed a Structured and Codified Sig Format Implementation Guide to support Structured and Codified Sig. Greater utilization of Structured and Codified Sig will present prescribers, pharmacists, and patients with an opportunity to improve safety and enhance workflow efficiency.

Barriers to adoption and use

Studies show unintended consequences of e-prescribing systems include changes in communication patterns, generation of new kinds of errors, more and new work for clinicians, unfavorable workflow issues, overdependence on technology, continuous demands for system upgrades, persistence of paper, negative emotions toward the technology, and changes in power structure and work roles.[16, 17]

A principal barrier and challenge to e-prescription adoption is implementation. The cost of implementing e-prescribing technology can be the primary limiting factor. According to the Health Resources and Services Administration, the total cost of implementing an e-prescribing system was found to be $42,332, with annual costs after implementation of about $14,725 per year for a practice of 10 full-time equivalent psychiatrists.[1] A 2007 study by Scalise and colleagues revealed that the cost to implement a basic e-prescribing program ranges from $1,500 to $4,000 per physician and the price for an advanced system with alerts, reminders and system integration is $29,000 per physician in the first year and $4,000 per physician every year thereafter.[18] The DEA in 2010 estimated the costs to implement the appropriate systems for EPCS, across pharmacies, hospitals and practitioners, to be between $43 million and $1.54 billion, annualized over 15 years.[19] In addition to the cost of implementing e-prescribing technology, the time investment and training required can also present barriers to adoption.

Another challenge associated with e-prescribing is related to system errors and network challenges. A key concern for system errors in e-prescribing is related to the impact on quality and the potential to cause medical errors. Many systems have CDS tools, but there are considerable variances of capabilities across platforms. Design issues with CDS tools can present serious risks, for example in the programming of too few or too many alerts. A lack of alert specificity can result in missing an adverse drug reaction, while an overload of alerts can produce the phenomenon known as alert fatigue, which can result in providers overlooking and ignoring important alerts.[20] In addition, many physicians report technical problems and poor network connectivity as a key barrier in e-prescribing adoption. In some instances, pharmacies are not reliably receiving and processing prescriptions sent electronically due to poor connectivity or network issues. This also has a negative downstream effect on patients due to delays in filling medications.

Privacy and security issues also present concerns with e-prescribing processes. It is important for prescribers to have appropriate security parameters in place to safeguard protected health information (PHI). Protecting data securely is an ongoing and constant requirement and challenge for providers, especially with many web-based tools and multiple opportunities for information to be stolen or compromised. In addition, many information breaches often originate from internal employee actions, which can be costly and require additional and ongoing training and security.[21]

Other barriers to efficient e-prescribing result from regulations of EPCS, enforced by the DEA. In 2010, the DEA legalized e-prescribing for Schedule II to Schedule V controlled substances. A dozen states have passed laws mandating the use of e-prescribing for controlled substances, some of which will be effective in 2020. The DEA ruling enforces strict standards for implementation and utilization, including identity proofing, two-factor authentication, digital certificates, monthly logs, third-party audits of software, and a requirement to keep two years of records.[19] The SUPPORT for Patients and Communities Act, enacted in 2018, further requires that all providers use EPCS by January 1, 2021.[22]

Two-factor authentication adds multiple additional steps to a prescriber's process.[5] Board of Trustees Report 6-I-17 described in detail the barriers associated with two-factor authentication: While authentication through a combination of personal identification numbers (PINs), passwords, and biometrics increases the security of EPCS, it also contributes to frequent workflow disruptions and increases costs for many physicians. An AMA survey found that primary care physicians write up to 100 prescriptions per day. Other specialists usually write an average of 10 to 25 prescriptions per day. This volume of prescriptions makes compliance with two-factor authentication, particularly as a distinct process from e-prescribing of non-controlled substances onerous and a significant strain on practice workflows. Few health information technology (HIT) vendors currently support EPCS, and those that do often require physicians to purchase add-on modules or

pay separate monthly service fees outside those of normal product maintenance. In speaking with many DEA-registered physicians, the AMA has found that many methods and processes HIT vendors utilize for EPCS are not well-aligned with normal e-prescribing workflows. In most instances, physicians must initiate an entirely new set of computer programs and windows each time they wish to use EPCS. The AMA shared with the DEA that cumbersome workflows and applications that do not take physician needs into account are the primary impediment to physician EPCS uptake and should be squarely addressed by system designers and product implementers. The DEA requirement that biometric devices comply with Federal Information Processing Standards (FIPS) compounds this problem by limiting many user-friendly consumer electronics already found in physicians' offices from being utilized. The AMA asked that the DEA reexamine the scope of technology that is compliant with EPCS requirements and allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.[23] The SUPPORT for Patients and Communities Act requires the DEA to update its regulations pertaining to how prescribers authenticate prescriptions using biometric devices.[22]

In addition to the requirements and time to e-prescribe controlled substances, providers also cite general clinic operational inefficiencies. Commonly cited challenges are time pressure on busy clinic days and frustration with time devoted to administrative portions of the e-prescription process, such as pharmacy selection and populating e-prescribing systems with patients' identifying information.[15] Real-time benefit check applications integrated into the EHR can help gain efficiencies, but are not yet a universally utilized tool. Cancelling an electronic prescription often involves multiple steps and phone calls to the pharmacy, which can be burdensome and time-consuming, and can add to the risk of medication errors. Integration of state prescription drug monitoring program (PDMP) data into the e-prescribing software could also help reduce workflow burdens. CMS in 2018 encouraged states to improve their PDMP systems to enable integration of PDMP data with EHRs.[24]

Another documented barrier is the excessive cost of complying with EPCS requirements. As reported in BOT 6-I-17, many physicians—especially those in small and solo practices—face high fees associated with the extensive technical, security, and other standard requirements (e.g., costs for identity proofing, access control training and the setting of access controls, hardware, software or application purchase and maintenance, reprogramming, and audit requirements), along with workflow adjustments needed for EPCS. In addition to the costs of compliance with EPCS, there are also monthly fees levied by HIT vendors. These fees and costs pose a significant barrier to EPCS adoption. The DEA registration fee for EPCS is $731 for three years and covers the costs of its diversion control program.

Finally, some prescribers perceive the process of searching and selecting a pharmacy each time a prescription is ordered electronically to be time-consuming and error-prone. Challenges can occur when prescriptions need to be transferred from one pharmacy to another, sometimes a result of patients relocating or changing health plans. Disruption in adherence can occur if pharmacies don't stock particular medications and it becomes difficult for patients to fill their prescriptions. Health plan changes also sometimes result in changes in pharmacy network status, which can lead to unexpected coverage gaps. Additional costs to obtain a non-preferred pharmacy prescription may only be realized when the patient picks up the prescription, resulting in phone calls from the patient back to the prescriber for help. Most commercial e-prescription systems offer a function to select a preferred pharmacy for patients. Other systems may also feature a "previously used pharmacy" option, which keeps a list of pharmacies at which the patient has historically filled prescriptions. Use of either of these functions, and regular verification of the indicated pharmacy, saves time and reduces the risk of selecting an erroneous pharmacy.[25]

Interventional case studies

Given the amount of time and resources dedicated to ensuring prescriptions are authorized, filled and renewed safely and efficiently, and in light of government focus on improving care quality, many practices have implemented changes to improve their e-prescribing processes and outcomes.

For example, researchers at Texas Children's Hospital implemented quality improvement interventions to improve e-prescribing.[26] Surveys and focus groups were conducted with patient families and pediatric residents to identify barriers and propose solutions to support efficient e-prescribing. These data were used to generate a series of interventions: (1) provider education; (2) changes in patient registration workflow; and (3) electronic health record changes to improve the frequency of e-prescribing on the pediatric hospital medicine (PHM) service.

One intervention was identified through the resident surveys which noted the absence of a preferred pharmacy in the patient's EHR as a barrier to e-prescribing. Following this observation, registration personnel were trained on entering preferred pharmacy information, and it was added to their EHR workflow. Because personnel already input patients' pediatrician information and other demographic data in the EHR, it was deemed an appropriate intervention to address this gap. Another intervention included an EHR build that required residents to assign an authorizing attending provider for discharge prescriptions, whether printed or e-prescribed. This enhancement ensured that attending information would be linked to all prescriptions for appropriate insurance processing and follow-up, whereas prior to that, residents were limited to manually writing in the attending name on printed prescriptions only, since the functionality was not allowed in the e-prescribing system. Texas Children's Hospital also designated e-prescribing as the default method of prescription for all providers system-wide, and forcing providers to actively opt out of e-prescribing. The build included an in-line validation to ensure that prescription orders were eligible for e-prescribing and that all necessary information was present.

This onsite research resulted in an increase in e-prescribing frequency on the PHM service from a median of 7.4% to 48.9%, which was sustained for an additional six months. The frequency of PHM prescription errors was unchanged.[26]

Marceglia et al identified six main phases of the e-prescribing process and proposed an updated comprehensive model for the e-prescribing process able to represent, analyze, and compare current systems and to support the design of new, more general, systems. Researchers identified six key phases of the e-prescribing process: Assign, Transmit, Dispense, Administer, Monitor, and Analysis Decision. The evaluation of systems completed in developing this model identified efficiency benefits primarily in the drug management controls within the e-prescribing systems. This model-based implementation of each phase is shown to have an impact on the quality of care, access to care, and the effectiveness of care delivery.[27]

A 2011 case study tested the effects on prescribing errors of transitioning from a local EHR with minimal CDS to a new EHR with robust CDS for e-prescribing. Overall prescribing error rates declined significantly one year after implementation, the main improvement being a reduction in inappropriate abbreviation errors. At 12 weeks post-implementation, however, rates of non-abbreviation errors peaked and there was no significant improvement after one year, suggesting that there are still safety risks in transitioning to an e-prescribing system that features more robust CDS.[14] Prescribers in this intervention, who were experienced e-prescribers, were surveyed for a parallel qualitative study. The participants found the transition to be extremely difficult and the EHR was not perceived to improve safety.[28]

Another case study identified an approach to simplifying the overall prescription renewal process. Synchronized, bundled prescription renewal, a systematic approach to prescription management, can decrease patient inconvenience, support medication adherence, and save one to two hours of physician and staff time each day.[29] In this system, the prescriber renews all chronic medications (except narcotics and benzodiazepines) at the annual comprehensive care visit, allowing for sufficient refills to last until the next annual visit. This eliminates the need for the physician and staff members to repeat the work of renewing each medication at interval visits. The AMA offers a STEPS Forward module on synchronized prescription renewal that is available with CME through the AMA Education Center.[30]

AMA efforts

In addition to comprehensive policy on e-prescribing and educational content on synchronized prescription renewal, ongoing AMA advocacy has succeeded in addressing a number of concerns about e-prescribing practices and regulations. The AMA continues concerted engagement to address specific barriers to e-prescribing of controlled substances due to overly burdensome DEA regulations. In the past, the AMA provided comments as part of the DEA's rulemaking process, raising concerns with a number of regulations and requirements. More recently, the AMA again met with the DEA and reinforced and expanded on those recommendations that would enhance security (and decrease diversion) while streamlining the administrative burden. The AMA noted that many physicians have reported that a well-designed electronic prescription system adds value to their practice of medicine and supports better patient care.[23]

Recommendations for improvements to e-prescribing practices

Surescripts published "E-Prescribing Quality Guidelines" which offers e-prescribing clinicians and EHR vendors comprehensive guidance on key principles and best practices to consider when initiating and transmitting electronic prescription orders.[2] Based on these best practices, and the literature and case studies reviewed, several recommendations for improving e-prescribing processes can be offered.

Some improvement efforts are already part of AMA's ongoing commitment to optimizing the use of e-prescribing in medical practice, as outlined in the AMA policies previously discussed. For example, the AMA advocates for:

- States to work toward unifying prescription standards and standard vocabularies
- The DEA to ease authentication requirements for prescribing controlled substances, including the scope of technology that is compliant with EPCS requirements
- HIT developers to improve interoperability between prescriber interfaces and mail-order prescription services and pharmacies

Other opportunities for improvements in e-prescribing processes are possible for a number of stakeholders.

- Implementation teams can conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
- Health care organizations and implementation teams can improve prescriber end-user training and on-going education.
- Implementation teams can prioritize the adoption of features like Structured and Codified Sig formats that can help address quality issues.

- Implementation teams can enable functionality of pharmacy directories and preferred pharmacy options. Leadership can encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
- Implementation teams can enhance EHR function to require residents assign an authorizing attending physician.
- Organizational leadership can implement e-prescribing systems that feature more robust clinical decision support, but ensure prescriber preferences are tested and seriously considered in implementation decisions.
- Organizational leadership can assign e-prescribing as the default prescription method.
- The DEA can allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
- Health insurers, pharmacies and e-prescribing software vendors should enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
- States can allow PDMP/EHR integration to reduce workflow burden and increase efficiency.

CONCLUSION

The increase in use of e-prescribing and the incentive programs aimed at encouraging its adoption have invigorated progress in improving the safety and efficiency of prescribing medications, but there is still much room for improvement. While errors related to legibility issues or misinterpretation of handwriting have been reduced, rates of medication errors have declined, and organizations have experienced better patient satisfaction and cost savings, the trade-off is the additional time prescribers spend maneuvering multiple platforms and completing data entry tasks required to order prescriptions. Many physicians appreciate the benefits that e-prescribing has provided, but recognize that improvements can still be realized to make them as safe as possible for patients and efficient as possible for prescribers. These improvements may be possible through the recommendations outlined in this report.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 237-A-18 and that the remainder of this report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
    a. H-125.979, "Private Health Insurance Formulary Transparency"
    b. D-120.956, "Electronic Prescribing and Conflicting Federal Guidelines"
    c. H-120.941, "e-Prescribing of Scheduled Medications"
    d. D-120.958, "Federal Roadblocks to E-Prescribing"
    e. D-120.945. "Completing the Electronic Prescription Loop for Controlled Substances" (Reaffirm HOD Policy)

2. That the second paragraph of AMA Policy D-120.972, "Electronic Prescribing," be rescinded as having been fulfilled by this report. (Rescind HOD Policy)

3. That our AMA encourage health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error,

improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

- E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
- Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
- Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues.
- Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
- Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
- Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
- Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician.
- Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
- Organizational leadership to designate e-prescribing as the default prescription method.
- The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
- States to allow integration of PDMP data into EHR systems.
- Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status. (New HOD Policy)

Fiscal Note: Minimal - Less than $500

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REPORT 21 OF THE BOARD OF TRUSTEES (A-19)
Augmented Intelligence (AI) in Health Care
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting of the American Medical Association (AMA), the House of Delegates (HOD) adopted amended policy recommendations of Board of Trustees (BOT) Report 41, "Augmented Intelligence (AI) in Health Care," in lieu of Resolution 205-A-18, "Augmented Intelligence," introduced by the American Academy of Pediatrics. However, the HOD referred the following proposed additional recommendation to the report for a BOT Report at the 2019 Annual Meeting: "AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not become a requirement that must be incorporated into the care of every patient." The referral was prompted in part due to testimony that the resolve was too narrowly focused and should address payment policy for health care AI. Since the resolve was referred, there has been significant federal and state legislative and regulatory activity related to health care AI, including the U.S. Food and Drug Administration's authorization of several AI-enabled software systems for clinical practice and the Centers for Medicare & Medicaid Services launch of an AI Health Outcomes Challenge in partnership with the American Academy of Family Physicians in order to incorporate AI in the implementation of both current and new payment and service delivery models. This underscores the benefit of developing AMA policy to address payment for AI systems without limits on medical specialty, practice setting, or payment model.

Existing health care AI policy provides that our AMA will "[p]romote development of thoughtfully designed, high-quality, clinically validated health care AI that is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; is transparent; conforms to leading standards for reproducibility; identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information. The policy also provides that the AMA will explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This report summarizes the need for additional AMA policy that is relevant to payment and use of health care AI; provides definitions of related terms; and addresses key issues that impact physician adoption of new health care technologies and delivery modalities, including clinical efficacy, usability and workflow integration, and liability. The recommendations build upon existing AMA policy and will enhance our AMA's continued engagement with a broad cross-section of stakeholders and policymakers to ensure that the perspective of physicians in various practice settings informs and influences the dialogue as this technology continues to develop.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-19

Subject: Augmented Intelligence (AI) in Health Care

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

At the 2018 Annual Meeting, our American Medical Association's (AMA) House of Delegates (HOD) adopted Board of Trustees (BOT) Report (Report) 41-A-18, "Augmented Intelligence (AI) in Health Care" policy recommendations as amended in lieu of Resolution 205-A-18, "Augmented Intelligence," introduced by the American Academy of Pediatrics. However, the HOD referred the following proposed additional recommendation to the report for a BOT Report at the 2019 Annual Meeting.

> AI should be funded as an enhancement of the primary care medical home so that patients who really need AI can benefit from the technology and such that AI does not become a requirement that must be incorporated into the care of every patient.

The reference committee heard overwhelmingly supportive testimony on BOT Report 41-A-18 and mixed testimony on Resolution 205. The reference committee heard testimony that physicians must provide a clear set of policy positions on health care AI to ensure the best interests of patients are served. The reference committee noted that Resolution 205 intends to advance important goals of health care AI such as ensuring it is part of workflow, that it is not mandated for use, and it strengthens the medical home. The reference committee noted that BOT Report 41 captures those goals and establishes policy that addresses additional important issues such as guarding against bias, application to specialty care, and the legal implications of health care AI.

The reference committee heard further testimony that federal and state legislators and policymakers are already developing laws and regulations on health care AI. The reference committee agreed with testimony that physicians have a critical perspective and must engage now to ensure this technology is developed in a way that improves patient outcomes, reduces administrative and technological burdens, and contributes to physician professional satisfaction. The reference committee heard testimony offering an amendment to safeguard patients' and individuals' privacy interests. Finally, the reference committee recommended adoption of BOT Report 41 with amendment in lieu of Resolution 205.

TERMINOLOGY[1]

The AMA's BOT Report 41-A-18 and the AMA's Council on Long Range Planning and Development's (CLRPD) Primer on Artificial and Augmented Intelligence establish definitions related to key AI systems, methods, and techniques. In this report on payment, it is essential to specify systems that augment the work of clinicians do so by assisting the decision making or by offering fully automated (autonomous) assistance. Furthermore, it is necessary to define and

differentiate between AI systems that utilize machine learning (ML) where there is either (1) a continuous learner algorithm or (2) a locked learner algorithm. The foregoing approaches have critical implications for risk, safety, regulation, liability, and, as a result, cost of integration into clinical practice (whether in a health system or a physician practice).

Augmented Intelligence and the Human – Machine Dyad

Although AMA physician leaders considered using the term "artificial intelligence," ultimately through the HOD process it was determined that the term augmented intelligence more accurately reflects the purpose of such systems, whether assistive or fully autonomous, because they are intended to coexist with human decision-making.[2] As we enter what many experts view as the fourth industrial revolution, it is important to update terms to explicitly articulate the expectation that rapidly evolving technologies should complement and extend the work of humans. And, the AMA is not alone in this measured view of what current AI systems in health care are able to do and what the expectations should be for the future development of such systems. The term "augmented" intelligence has become the preferred term among key technology companies,[3] other innovators, and physician AI experts. While one leading expert has advocated the use of the term "dyadarity" to underscore the human-machine dyad, the rationale for the use of the term dyadarity also points to the appropriateness of the use of the term "augmented intelligence:"

> As we embed more and more machine learning in our clinical decision support and in our clinical workflows (face to face [and] virtual care), we will discover far more interaction and meshing between human and machine, physician and computer. The notion that the machine will acquire absolute superiority over the human in decision-making implies that the output of the machine will be strictly deterministic, as if it were just like the result of a serum sodium level. . . . Incorporating […] highly variable and contextual human considerations into the treatment plan really requires thoughtful and empathic discussion between doctor and patient. The literature is now replete with references to various types of bias associated with how machine learning is applied to different people in different contexts. Similarly, there are over 100 cognitive biases that have been well documented in human decision-making. What we will really need as physicians is assistance in how to more systematically surface and expose the biases of both the machine, also known as "thinking in silico" and the human "thinking in carbon," in ways that allow the individual physician to manage, reconcile when possible, and mitigate those biases. This will become more of a collaborative exercise and the notion of a machine-superiority emerging after the "singularity is here" will begin to fade into a more realistic "dyadarity" where all potential bias and ethical issues are made more transparent, but ultimately the human will be responsible for making the decision.[4]

As noted in BOT Report 41-A-18, "combining machine learning software with the best human clinician 'hardware' will permit delivery of care that outperforms what either can do alone."[5] Other physicians have noted that "the applications of AI to 'augment' physicians is more realistic and broader reaching than those that portend to replace existing health care services."[6] Other early adopters of such systems note that "[t]he difference between artificial intelligence and augmented intelligence may seem inconsequential to some; it could quite literally make a world of difference when it comes to how we approach robotics in the decades to come ... [and] [i]t's businesses using the technology to supplement rather than replace their employees that stand to benefit most from the further development and refinement of this technology."[7] In sum, whether AI systems are assistive (such as clinical decision support programs) or fully autonomous (such as software programs that provide a definitive diagnostic decision), these rapidly evolving systems should augment and scale the capabilities of physicians, the broader health care team, and patients in achieving the quadruple aim in health care.[8]

Machine Learning (ML): Continuous Learning System and "Locked" Model

The term AI covers a range of methods, techniques, and systems. Common examples of AI systems include, but are not limited to, natural language processing, computer vision, and ML. In health care, as in other sectors, AI solutions may include a combination of these systems and methods. ML presents some of the thornier regulatory and oversight challenges that implicate cost and payment.

An AI system utilizing ML employs an algorithm programmed to learn from data referred to as "training data." [9] The learner algorithm will then automatically adjust the ML model based on the training data. In health care, it is important to know whether the learner algorithm is eventually locked or whether the learner algorithm continues to learn once deployed into clinical practice. A "continuous learning system" continues to update the model without human oversight as new data is presented to the learner algorithm, whereas "locked learners" will not automatically update the model with new data. There are both benefits and risks to continuous learning systems which may:

> …more precisely calibrate suggestions to specific demographic or geographic areas over time, taking into account [for example] that certain diagnoses are more common in that setting and/or adjusting for local norms in the input data formatting or presentation. However, as software changes, the rate and distribution of false-positives and false-negatives may also change, potentially in ways that no longer have an acceptable benefit-risk profile. As such, there are serious concerns about the risks and ethics of deploying a continuously learning software system in the clinical setting.[10]

Current AI systems developed utilizing ML for clinical applications that have been authorized by the U.S. Food and Drug Administration (FDA) involve a two-step process. First, the learner algorithm remains "on" until the model, a software tool, has been developed with enough "training data." The learner algorithm is then "locked" and model is not updated in real time. In short, "once an AI system is developed utilizing a learning algorithm, it can be 'locked' and used without automatic updates."[11] Why lock the learner algorithm? When AI systems are applied to patient clinical care, it is necessary to allow developers (and regulators where the system is considered a medical device) to undertake safety and clinical efficacy testing. However, reportedly, developers may run a parallel AI system with a learner algorithm still "on" in order to assess quality and identify enhancements. The developer will update the AI system which has a locked learner on a periodic basis after validation for clinical efficacy and safety. This has been characterized by certain innovators as "discontinuous learning."[12] In addition, it has been noted that if these regular updates are not done, "locked models have the potential to degrade over time if inputs change significantly."[13]

While there are significant benefits and needed health care transformations that AI systems using ML promise to produce, careful consideration should be given to clinical applications of such systems and the attendant quality and safety challenges. A group of British and U.S. experts has proposed a general framework for identifying and addressing short-, medium-, and long-term quality and safety issues vis-à-vis AI systems utilizing ML for clinical applications including distributional shift, insensitivity to impact, black box decision-making, unsafe failure mode, automation complacency, reinforcement of outmoded practice, self-fulfilling prediction, negative side effects, reward hacking, unsafe exploration, and unscalable oversight.[14]
Furthermore, all AI systems are reliant upon data, but ML amplifies the risks associated with an incomplete understanding or disclosure of data origin (often called provenance) and bias. Data often can be incomplete and contain erroneous information[15] and all data is biased in some manner.[16] It is imperative to disclose and provide means to address AI system bias in order to

avoid, among other unintended outcomes, exacerbating health disparities and other inequities. Developers of AI systems used for clinical care should—as soon as there is a preliminary validation of a clinically relevant bias or potential patient safety risk associated with any of the recommendations emerging from an AI system—report the bias to the users of that software (appropriate institutional notification should suffice for institutions with many users). Developers of AI systems used in clinical care should be required to maintain an active intake process for reports of such issues from end-users, and there should be transparency into those reporting and quality assurance processes. Developers must have a process for continuous efficacy monitoring. In addition, there should be transparency into key attributes of the population that was the source of training data set while ensuring the protection of individual patient data and privacy interests. The purpose of this transparency is to enhance the understanding of risk associated with applying an AI system to individuals whose personal characteristics may diverge in significant ways from the population in the training data set. Finally, there should be transparency and "traceability" of training data.

USES AND APPLICATIONS OF AI SYSTEMS IN HEALTH CARE

A prerequisite to payment for AI systems involves identifying, at minimum, the intended use of the AI system, whether it is assistive or fully autonomous, conditions required for successful deployment, and the level of regulatory oversight required to ensure patient safety and the clinical efficacy of the system. These factors, along with associated liability risk, impact costs and sustainability. Broadly speaking, AI systems can be used in many areas of health care, including, but not limited to: (1) research; (2) education and workforce professional development; (3) finance, business processes, and health administration; (4) tools and services that improve medical practice, e.g., cybersecurity; (5) population health and public health; (6) patient and caregiver engagement and prevention; and (7) clinical care, e.g., clinical decision support or autonomous diagnostic system. Furthermore, when used in the foregoing areas, AI systems can function to automate repetitive and time-intensive tasks, improve communication and interactions, and enhance decision-making which improve efficiency and accuracy.

Key AI System Considerations, Standards Development and Ongoing Research

While overall research on clinical applications of AI systems continues to grow rapidly, there is a paucity of peer-reviewed publications of the results of head-to-head comparisons between physicians and AI systems. The specialty areas where such research exists include: radiology, neurology, pathology, dermatology, ophthalmology, gastroenterology, and cardiology.[17] There is growing research in other areas such as oncology, but not necessarily comparative. Increased funding and support for research into AI system applications in health care, particularly for specific clinical applications, will remain a critical priority. However, research on AI system applications in the areas of population health, patient engagement, and health administration will also produce important findings of benefits and possible unintended consequences (such as inequitable impact). Experts have also noted that the following areas of research remain a priority:

- Verification. Research into methods of guaranteeing that the AI systems meet established specifications.
- Validation. Research into ensuring that the specifications, even if met, do not result in unwanted behaviors and consequences.
- Security. Research on how to build systems that are increasingly difficult to tamper with – internally or externally.
- Control. Research to ensure that AI systems can be interrupted (even with other AIs) if and when something goes wrong, and restore normal function.[18]

Other priority areas include research into explicability (which is also referred to as explainability) which is receiving significant focus by U.S. federal agencies and Congress. Widespread deployment and scaling of advanced AI systems utilizing, for example, ML in health care has not yet occurred. Conditions of deployment will require continued attention to assess safety, efficacy, and fairness. And, while existing standards must be met, additional ones are needed to address specific issues raised by AI and ML. For example, in February 2019, the British Standards Institution (BSI) and the Association for the Advancement of Medical Instrumentation issued a position paper with recommendations to support governance and regulation of AI and ML in health care to specifically address: (1) level of autonomy; (2) changing outputs of algorithms; (3) explicability; (4) transparency; and (5) quality of data outputs.[19] Federal agencies and Congress are also prioritizing research and standards developments (as discussed below).

Legal Requirements

Depending on the intended use of an AI system, there are several legal requirements that developers must adhere to when marketing AI-enabled software if commercializing for mass distribution or when a health system designs, develops, and implements AI-enabled software within their own health system.[20] AI systems with clinical applications that meet the existing definition of medical device under the Food, Drug, and Cosmetic Act (FDCA) must comply with the FDA requirements related to safety and efficacy. Some of these AI systems may be subject to enforcement discretion because the FDA considers the risk of harm as it relates to a host of factors including intended use and conditions of deployment for example, sufficiently low.

Even where AI systems are not subject to the FDCA, the development, marketing, and deployment can be subject to a host of other federal and state laws. Some of the key laws include the:

- Health Insurance Portability and Accountability Act (HIPAA). HIPAA is meant to protect the privacy and security of protected health information. Certain entities are required to provide notifications of health information breaches. There are state laws that provide enhanced protections. In addition, there are newly emerging international standards such as Europe's General Data Protection Regulation (GDPR) that impact developers that reach global markets.
- Common Rule (Protection for Human Subject Research). Each federal agency that follows the Common Rule has guidance on federally funded research involving human subjects.
- Federal Trade Commission Act (FTCA). The Federal Trade Commission (FTC) has the authority to take action against developers of AI systems that engage in deceptive and unfair trade practices. This is most relevant where the developer makes false and misleading health claims, representations regarding the performance of an AI system, or claims that impact consumer data security and privacy. The FTC also provides enforcement of the Health Breach Notification Rule which applies to certain businesses that are required to provide notifications to consumers after a breach of personal health record information.

The above laws apply to AI systems with clinical uses (though the Common Rule will not always be applicable). Developers, regulators, and standards setting bodies must identify dynamic and useful mediums and methods to ensure physicians, medical staff, third-party payers, and patients who rely on AI-enabled systems understand whether (or not) the developer has complied with the relevant federal and state laws.

HEALTH CARE AI INVESTMENTS, ACQUISITIONS, AND PATENTS

The rapid growth in health care AI investments, acquisitions, and patents is expected to continue on a steep upward trajectory. Analysts report that the AI health market investment is expected to reach

$6.6 billion by 2021, a 40 percent compound annual growth rate.[21] In addition, health care AI startups have raised billions since 2013, which exceeds all other industries in AI deal activity.[22] A harbinger of this interest involves one of the largest merger and acquisitions deals in health care AI. Specifically, Flatiron Health was acquired by Roche Holdings for $1.9 billion largely due to the curation of patient data by clinical experts that can be mined using AI systems employing ML.[23] The rapid rise in patent applications involving AI in the health care field is also significant. There were 79,936 patents filed in the United States between 2010 and 2018, with the plurality being in the health field (32.6 percent).[24] Some of the patents are very broad or seek to patent the obvious and, thus, may not ultimately be enforceable. However, such patents could create barriers to other innovators and increase costs due to litigation. While support for AI in health care is based on the promise of advancing the quadruple aim including lowering health care costs, manipulations of the patent system may result in higher health care costs and perversely chill innovation.

CONGRESS, FEDERAL AGENCIES, WHITE HOUSE AND FEDERATION OF STATE MEDICAL BOARDS (FSMB)

Since the HOD adopted the recommendation of BOT Report 41-A-18, federal and state government activity has intensified rapidly. At the federal level, Congress and the Administration are taking steps to advance the use of AI systems for national security purposes and to ensure U.S. global economic competitiveness. The following summarizes the wide-range of actions from the various congressional committees, federal agencies, the White House, and FSMB. However, this BOT Report does not detail government activities[25] focused on data issues, which are broader—although germane—in scope than AI. These issues could be addressed in a future board report.

Congress

Congressional interest in AI continues to grow, although both chambers are primarily in the fact gathering and member education stages. In 2018, Representatives John Delaney (D-MD) and Pete Olson (R-TX) launched the AI Caucus to "inform policymakers of the technological, economic and social impacts of advances in AI and to ensure that rapid innovation in AI and related fields benefits Americans as fully as possible." A number of congressional hearings concerning AI have taken place.[26]

While a number of bills covering AI were introduced but not passed in the 115th Congress, [27] the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (H.R. 5515) became law and had a provision regarding AI. Section 1051 of the law requires the establishment of the National Security Commission on AI to provide recommendations to Congress and the President via an annual report on AI. The law directs the Secretary of the U.S. Department of Defense (DOD), no later than one year after the date of the enactment of law, to delineate a definition of the term "artificial intelligence" for use within the DOD. However, the law provides that AI should include:

- Any artificial system that performs tasks under varying and unpredictable circumstances without significant human oversight, or that can learn from experience and improve performance when exposed to data sets.
- An artificial system developed in computer software, physical hardware, or other context that solves tasks requiring human-like perception, cognition, planning, learning, communication, or physical action.
- An artificial system designed to think or act like a human, including cognitive architectures and neural networks.

- A set of techniques, including machine learning, that is designed to approximate a cognitive task.
- An artificial system designed to act rationally, including an intelligent software agent or embodied robot that achieves goals using perception, planning, reasoning, learning, communicating, decision making, and acting.[28]

In September 2018, the U.S. House of Representatives Oversight and Government Reform Subcommittee on Information Technology former Chairman Will Hurd (R-TX) and former Ranking Member Robin Kelly (D-IL) released a white paper, titled "Rise of the Machines: Artificial Intelligence and its Growing Impact on U.S. Policy." The white paper outlines three areas of concern including: public safety, innovation, and investment in research and development. Notably, the report contains a recommendation that the federal government should review existing oversight of AI systems in order to assess whether it is sufficient to ensure public safety. Where oversight is not adequate, the subcommittee recommended that Congress and the Administration modernize oversight while not overregulating.

In February 2019, the House Energy and Commerce Committee Subcommittee on Consumer Protection and Commerce scheduled a hearing on diversity in the technology industry. Though it had to be rescheduled, the Committee Chairman Frank Pallone (D-NJ) and subcommittee Chairwoman Jan Schakowsky (D-IL) issued a joint statement concerning AI systems and bias. Specifically, they noted that a lack of diversity can affect the design of AI. And, the foregoing could compound the risks of AI systems as the data used to train certain AI systems may amplify bias and lead to discriminatory outcomes.

White House

In May 2018, the White House hosted a summit with business leaders, government officials, and academics to identify how the U.S. government could increase AI research and prepare the U.S. workforce for the disruptions that AI will bring. Officials from most cabinet-level agencies participated including the HHS Deputy Secretary as well as the HHS Chief Technology Officer. The health care AI panelists included representatives from CVS, Johnson & Johnson, Medtronic, Quest Diagnostics, Google, IBM, and Verily, a subsidiary of Google. At the conclusion, the Administration announced the establishment of an advisory committee comprised of federal agencies and issued a report and memorandum.[29]

In February 2019, a Presidential Executive Order was issued launching the American AI Initiative. The Initiative encompasses five key areas: (1) prioritization of investment by all federal agencies in AI research and development (R&D); (2) requiring federal agencies to make federal data, models, and computing resources more available to U.S.-based AI R&D experts, researchers, while maintaining the safety, security, civil liberties, privacy, and confidentiality protections of Americans; (3) establishing guidance for AI development and use across different types of technology and industrial sectors and directing the National Institute of Standards and Technology (NIST) to lead the development of appropriate technical standards for reliable, robust, trustworthy, secure, portable, and interoperable AI systems; (4) requiring federal agencies to prioritize fellowship and training programs to help U.S. workers gain AI-relevant skills through apprenticeships, skills programs, fellowships, and education in computer science and other growing Science, Technology, Engineering, and Math (STEM) fields; and (5) requiring federal agencies to develop and implement an action plan to protect the advantage of the U.S. in AI and technology critical to U.S. national and economic security interests against strategic competitors and foreign adversaries.[30]

Food and Drug Administration (FDA)

In April 2018, the FDA authorized for market an "autonomous" AI system, IDx-DR, that detects more than mild diabetic retinopathy. IDx-DR was not the first AI-enabled software that the FDA has cleared or authorized for market under the existing FDA legal authorities designed to ensure safety and efficacy; however, it is the first designated as fully autonomous, meaning that it provides a diagnostic output and management recommendations without medical specialist interpretation. IDx-DR is intended for use by primary care providers who may not have expertise of diabetic retinopathy. A clinical staff member is able to upload the digital images of the patient's retinas to the IDx-DR AI system. If the images are of sufficient quality, the system provides the medical practice with one of two diagnostic results: (1) "more than mild diabetic retinopathy detected: refer to an eye care professional" or (2) "negative for more than mild diabetic retinopathy; re-test in 12 months." If a positive result is detected, patients should be referred to a specialist for further diagnostic and treatment evaluation.

The issue of levels of automation in the context of clinical care has become a central question from both a regulatory perspective and for purposes of payment and coverage because a clinically validated autonomous system is labeled by the FDA to perform a service without medical specialist interpretation. The FDA did not identify specific criteria it used to designate the IDx-DR system as autonomous; however, it did set precedent for autonomous AI by requiring a preregistered clinical trial to establish safety, efficacy, and equity, as reflected by the three corresponding trial endpoints. Narrowly defined, equity means that the AI is accurate and effective for all subgroups of the intended population, including age groups, races and ethnicities, not just for one or a few. It requires both design and validation of the AI to address potential bias and sources of bias. Thus, equity is a component of both safety and efficacy. The FDA also established special controls for the autonomous IDx-DR device including software documentation requirements, the requirement for clinical data to evaluate image acquisition as part of the system, the requirement for human factors validation, and the requirement for labeling to include instructions for obtaining quality images and how performance is affected by users interacting with the system.

Also last year, the FDA permitted marketing of clinical decision support software that alerts providers of a potential stroke in patients. The Viz.AI Contact application is intended for use by neurovascular specialists and other professionals with similar training. The Viz.AI Contact application analyzes CT images of the brain and sends a text notification to a neurovascular specialist if a suspected large vessel blockage has been identified. The AI system automatically notifies the specialist during the same time that the first-line provider is conducting a standard review of the images, thereby involving the specialist sooner than the usual workflow in which a radiologist reviews CT images and then notifies a neurovascular specialist. The specialist still reviews the images on a clinical workstation. The application is limited to analysis of imaging data and has not been authorized by the FDA as a replacement of a full patient evaluation or to be relied upon solely to make or confirm a diagnosis.

Although AI system developers are able to utilize existing FDA regulatory pathways to secure approval, or *de novo* authorization for AI systems, the FDA has indicated that the Agency's alternative framework for oversight of software as a medical device (SaMD) could also serve as potential pathway to market AI systems considered medical devices. Software that is intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in humans meets the definition of medical device and is FDA regulated. However, certain software that would have met this definition of medical device is no longer subject to FDA oversight due to passage of the 21st Century Cures Act of 2016.

The FDA has two categories for software that qualifies as a medical device: SaMD and software in a medical devices (SiMD). The FDA is dedicating a substantial amount of time to develop a new voluntary SaMD oversight pathway for developers called the Precertification Program. The pre-certification designation would be analogous to the Pre-Check program used by airline travelers. Once initially vetted, a developer would go through a streamlined process. Simply stated, given the rate of modifications to software and with the advent of software based on continuous learning algorithms powered by deep learning and neural networks, the current oversight framework may be strained by the volume of software and entrance of new software developers.

Early in 2019, the FDA issued an updated version of the proposed Precertification Program. The FDA states that it contemplates that AI systems would be able to use the Precertification Program. Throughout 2019, the FDA intends to pilot the Precertification Program in order to assess how the program could maintain FDA standards for assuring safe and effective products, while still achieving its aim of modernizing and streamlining the FDA's review of novel digital health products. The FDA will test how the Precertification Program approach utilizing the streamlined *de novo* authorization pathway compares to the traditional FDA submission pathway. The AMA continues to provide comments and evaluate carefully the Precertification Program to assess whether it will ensure the safety and efficacy of software, particularly AI-enabled software that would be cleared, authorized, or approved through this pathway.

Centers for Medicare & Medicaid Services (CMS)

In November 2018, the CMS Center for Medicare & Medicaid Innovation (CMMI) announced a cross-industry challenge competition to innovate how AI can be implemented in current and future health care models dubbed the AI Health Outcomes Challenge. CMS noted it would seek applications for AI and analytics that can boost clinical care and improve overall patient health. The competition is open to technology vendors, clinicians, scientists, academics and patients who are innovating their uses of AI for quality improvement. In February 2019, it was announced that the challenge was being launched in partnership with the American Academy of Family Physicians. Reportedly, CMS is "brainstorming how [the Agency] can incorporate AI in the implementation of both our current and new payment and service delivery models."[31]

National Institutes of Health (NIH)

In July 2018, the NIH hosted a full-day public workshop titled Harnessing Artificial Intelligence and Machine Learning to Advance Biomedical Research. Subsequently, the NIH established an AI Working Group comprised of twelve members—drawn primarily from industry and universities. The AI Work Group is co-chaired by an engineering director at Verily, and the NIH's Principal Deputy Director. In December 2018 the AI Work Group provided an update as part of the Meeting of the Advisory Committee to the NIH Director. The charge of the AI Work Group includes making recommendations to address the following questions: (1) Are there opportunities for cross-NIH effort in AI? How could these efforts reach broadly across biomedical topics and have positive effects across many diverse fields? (2) How can NIH help build a bridge between the computer science community and the biomedical community? (3) What can NIH do to facilitate training that marries biomedical research with computer science? and (4) Identify the major ethical considerations as they relate to biomedical research and using AI/ML/deep learning for health-related research and care, and suggest ways that NIH can build these considerations into its AI-related programs and activities.

The AI Work Group will offer interim recommendations in June 2019 and final recommendations will be issued in December 2019. There are a range of additional NIH activities such as the NIH AI

Interest Group (AIIG) that is charged with facilitating communication among the scientists of NIH, FDA, universities and industries with interest in the development of AI systems to improve medical treatments. In August 2018, the NIH's National Institute of Biomedical Imaging and Bioengineering (NIBIB) hosted an Artificial Intelligence and Medical Imaging Workshop to discuss AI systems used for medical imaging and the challenges with regard to quality, reproducibility, and reliability of AI in medical imaging for clinical use. The meeting also sought to address how AI systems might improve the value of medical imaging and health care overall. In addition to ongoing NIH research, peer publications, and meetings, the Director of NIH also blogs concerning the research and evidence related to AI system applications to clinical care. In January 2019, for example, the Director posted a blog on Using Artificial Intelligence to Detect Cervical Cancer.

Federal Trade Commission (FTC)

In November 2018, the FTC held a two-day hearing on Algorithms, Artificial Intelligence, and Predictive Analytics. The hearing focused on: (1) the current and potential uses of these technologies; (2) the ethical and consumer protection issues that are associated with the use of these technologies; (3) how the competitive dynamics of firm and industry conduct are affected by the use of these technologies; and, (4) policy, innovation, and market considerations associated with the use of these technologies.

The developer of the IDx-DR program, a practicing physician, was invited by the FTC to provide testimony on the panel titled Understanding Algorithms, Artificial Intelligence, and Predictive Analytics Through Real World Applications. While he remarked that FDA has not set specific criteria for autonomous AI, the developer described proposed minimum criteria for autonomous AI and emphasized the need for rigorous FDA processes before deployment into clinical practice, including the three principles of safety, efficacy and equity. He also noted that AI developers with autonomous AI systems used for clinical applications must assume medical liability. The IDx-DR developer emphasized the importance of transparency; agreement on enforceable definitions; the minimum requirements for AI system validation, including human factors validation; requirements for addressing age, racial, and ethnic bias in the design; and validation of the AI system. He discussed the need for the highest-level reference standard based on patient outcomes, and aligned to the specialty preferred practice pattern, the importance of a pre-registered clinical trial reflecting the intended use, cybersecurity, training data stewardship, and other aspects unique to autonomous AI. The AMA filed comments which included the AMA policy on health care AI and expressing agreement that there is a need for: (1) clinical validation by regulators, (2) appropriate assignment of legal liability to developers for autonomous AI systems; and (3) transparency to support clinical decision-making.

Defense Advanced Research Projects Agency (DARPA)

In August 2016, DARPA launched the Explainable Artificial Intelligence (XAI) program. The program focuses on ML systems in order to: (1) produce more explainable models, while maintaining a high level of learning performance (prediction accuracy); and (2) enable human users to understand, appropriately trust, and effectively manage the emerging generation of artificially intelligent partners. In July 2018, DARPA launched the Artificial Intelligence Exploration (AIE) Program. And, then, in September 2018 the Agency announced a multi-year investment of more than $2 billion in new and existing programs called the "AI Next" campaign. Key areas of the campaign include automating critical DOD business processes, such as security clearance vetting or accrediting software systems for operational deployment; improving the robustness and reliability of AI systems; enhancing the security and resiliency of ML and AI technologies;

reducing power, data, and performance inefficiencies; and pioneering the next generation of AI algorithms and applications, such as "explainability" and common sense reasoning.

Federation of State Medical Boards

In April 2018, the FSMB House of Delegates resolved to convene relevant stakeholders, subject matter experts, including representatives from state medical boards, the AMA, and the American Osteopathic Association to discuss AI and its potential impact on patient safety, decision-making and regulation.[32] In November 2018, FSMB hosted AI in Health Care: The Role of Medical Boards. The Summit was comprised of a cross-section of stakeholders including representatives from the AMA and various state medical boards, FSMB leadership, staff, and industry. The discussion centered on the regulatory environment in which health related AI technology is deployed, the mission of state medical boards and approaches to AI regulation taken in other jurisdictions, and the appropriate role and function of medical boards in the deployment of health AI technology.

POLICY

The AMA's foundational Policy H-480.940, "Augmented Intelligence in Health Care," provides that the perspective of practicing physicians should be included in the development, design, validation, and implementation of health care AI. Furthermore, the policy provides that thoughtfully designed, high-quality, clinically validated health care AI must be designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; be transparent; conform to leading standards for reproducibility; identify and take steps to address bias and avoid introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and safeguard patients' and other individuals' privacy interests and preserves the security and integrity of personal information. The policy also provides that our AMA will address the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

In addition, AMA policy concerning payment for digital medicine and integration of health information technology are related to payment and use of AI systems in health care as the latter are a subset of the former.

AMA Policy H-480.946, "Coverage of and Payment for Telemedicine," provides that payment and coverage should only occur when delivered consistent with applicable regulatory and oversight requirements designed to ensure patient safety and consistent with clinical practice guidelines developed by national medical specialty societies and other evidence-based practice guidelines, to ensure patient safety, quality of care and positive health outcomes. Furthermore, the policy specifies appropriate disclosure, informed consent, and care coordination must be in place. The policy also provides that digital modalities should comply with laws addressing privacy and security of patients' medical information and urges physicians to verify that their medical liability insurance policy covers use of such technologies. In this latter regard, it will be important that physicians verify that AI system developers have taken steps to be legally responsible and accountable for the AI system where there is a lack of transparency or the developer is providing or marketing a fully autonomous AI system.

AMA policies (H-480.946 and H-480.940) outline the importance of: research to build the evidence base for digital medicine; federally funded pilots to assess new delivery models, scaling,

quality, and payment; and physician organizations and national medical specialty societies in particular in developing standards and clinical practice guidelines. The policies provide that physician organizations should collaborate with other key stakeholders in the development of technical standards for digital medicine, to the extent practicable, and to take the lead in the development of clinical practice guidelines. AMA policy also provides support for research to develop appropriate practice parameters to address the various applications of digital medicine modalities and to guide quality assessment and liability issues.

In addition to outlining essential prerequisites to payment such as evidence of clinical usefulness, compliance with state and federal legal requirements to ensure patient safety, and adherence to clinical practice guidelines, AMA Policy H-480.974, "Evolving Impact of Telemedicine," provides support for pathways to payment under existing payment and delivery models while also specifying that the AMA will work with CMS and other payers to develop and test through demonstration projects appropriate reimbursement mechanisms.

AMA also has policy concerning the acquisition and cost of health information technology. AMA Policy D-478.990, "Clinical Information Technology Assistance," provides that the AMA will seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors. And, a related Policy D-478.996, "Information Technology Standards and Cost," provides that our AMA will 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 and to take into account the cost to physicians at the office-based level; and to continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records Finally, the policy provides that our AMA will advocate that physicians not be financially penalized for certified EHR technology not meeting current standards.

DISCUSSION

The recommendation referred for report raises many of the same questions and concerns that physicians across medical specialty and practice sites have expressed when adopting new digital medicine modalities or when acquiring, implementing, and maintaining health information technology, as discussed below. In addition, since the referral, payment and use of AI systems in health care has rapidly taken on relevance as the FDA has authorized or cleared for use AI-enabled systems for clinical practice, including, as detailed above, the first autonomous AI-system. And, CMS in collaboration with the American Academy of Family Physicians has launched a challenge competition to innovate how AI can be implemented in current and future health care payment and delivery models.

AMA policies related to payment and coverage of digital medicine and acquisition of health information technology are directly applicable to funding, payment, and access to AI systems for health administration, population health, practice management, clinical care, and related use. However, AI systems do raise additional issues. Also, these challenges (and potential benefits) may impact physicians and their patients differently depending on the practice size, setting, and specialty and these are germane.

Advancing the Quadruple Aim for All Patients, Medical Specialties and Care Setting

The referred recommendation would establish AMA policy to support funding for AI systems as an "enhancement of the primary care medical home so that patients who really need AI can benefit from the technology." While this should be one of the outcomes of payment and funding policy for AI systems, it is not the only one. Instead, our AMA should support payment and funding for the range of practice types and specialties where different AI system uses will advance the quadruple aim. The quadruple aim seeks to advance simultaneously the improvement of the health of populations, the enhancement of the patient experience of care, the reduction of the per capita cost of health care, and the improvement the work life of health care clinicians and staff.[33]

In 2016, the AMA commissioned a survey of physicians from varied medical specialties and practice settings in order to investigate their motivations, current usage, and expectations for integrating digital medicine tools into their practice (Digital Health Study). The surveyed physicians were optimistic that digital medicine tools would improve medical practice and patient care. Surveyed physicians in larger practices tended to use digital medicine tools more. Key factors relevant to increased adoption included practice size and setting which suggests economies of scale and the ability of relatively larger practices to scale infrastructure may play a role in adoption. More physicians reported adoption of telehealth visits than use of remote patient monitoring. Physicians, however, have greater enthusiasm for the clinical benefit and work efficiencies of remote patient monitoring and management systems. It is anticipated that this latter modality will utilize increasingly advanced AI systems and methods. In addition, utilization of remote patient monitoring is expected to increase as a result of Medicare expanded coverage of remote patient monitoring for chronic conditions as of January 1, 2019.

In addition to needing credible evidence that a digital modality is clinically effective, surveyed physicians ranked in order of importance the key issues that must be addressed to support their adoption of these technologies including: (1) appropriate measures to address liability; (2) data privacy/security assured by experts; (3) workflow integration with electronic health record systems; and then, (4) coverage and payment. Similarly, our AMA policies specify that digital medicine payment and integration are subject to: (1) appropriate regulatory oversight; (2) accountability by technology developers for adverse events caused by such technologies; and (3) patient privacy and security protections.

The foregoing underscores that AMA policy should address payment for AI systems without limits on medical specialty, practice setting, or payment model. Furthermore, payment for such systems should ensure key issues and considerations are addressed as with all digital medicine modalities when incorporating these systems into practice, while also accounting for the additional risks that AI systems may pose.

Mandates, Penalties, Interference with Medical Practice, and Liability

The referred also would have established AMA policy that AI systems should not be "a requirement that must be incorporated into the care of every patient." If adopted, it would have only partially addressed a range of long-standing physician concerns related to technology mandates, penalties, and other similar requirements that interfere with the patient-physician relationship and medical practice while exposing physicians to increased liability. When technologies are well-designed and clinically validated and useful, mandates are not needed. Where technologies are poorly designed, mandates and penalties have been used to drive adoption. However, the approach to include mandates and penalties has stymied innovation and fueled physician burnout. As a result, it is important that payment policies incentivize development of AI

systems that: (1) are informed by real-world workflow and human-centered design principles; (2) enable physicians and other health care stakeholders to prepare for and transition to changes in care delivery; (3) support effective communication and engagement among patients, physicians, and the health care team; (4) seamlessly integrate into the clinical and administrative workflow; and (5) enable frictionless end-user feedback to support iterative product improvement.

Furthermore, mandated use of AI systems for specific clinical uses or health administration raise concerns as to the validation and scaling of AI systems for a range of applications that remain a work in progress. As detailed in this report, there is an ongoing need for standards development and wide-spread adoption of such standards, regulatory modernization, research, and experience with varied deployment models. There are significant risks associated with AI systems that are not properly designed, developed, validated and deployed as previously detailed in BOT Report 41-A-18. In brief, AI systems utilizing ML present pronounced risk of bias. Physicians, health systems, developers, or regulators may not be in a position to understand the risks due to black-box systems due to design or for proprietary reasons. Thus, mandated or required uses of such systems should be disfavored and liability should be borne by the developer and/or the entity mandating use of such systems whether fully autonomous or assistive.

Building Evidence Base

The foregoing underscores that there is the need to build the evidence base for health care AI. Research should prioritize evaluation of AI systems that utilize ML in clinical practice to assess safety, efficacy, performance, equity, privacy, and security under varied conditions of deployment. Public and private funding and other resources should be prioritized to support research that expands the evidence base for applications of health care AI systems.

RECOMMENDATION

In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of the recommendation and the remainder of this report be filed:

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) clinical evidence.

4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

8. Our AMA, national medical specialty societies, and state medical associations—
    a. Identify areas of medical practice where AI systems would advance the quadruple aim;
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
    c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
    d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

Fiscal Note: Less than $5000

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methods for human-AI collaboration; (3) Understand and address the ethical, legal, and societal implications of AI; (4)Ensure the safety and security of AI systems; (5) Develop shared public datasets and environments for AI training and testing; (6) Measure and evaluate AI technologies through standards and benchmarks; and, (7) Better understand the national AI research and development workforce needs.

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APPENDIX: RELEVANT AMA POLICY

Policy H-480.940, "Augmented Intelligence in Health Care"

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
   a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
   b. is transparent;
   c. conforms to leading standards for reproducibility;
   d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
   e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage 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.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Policy H-480.946, "Coverage of and Payment for Telemedicine"

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.

Policy H-480.974, "Evolving Impact of Telemedicine"
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.

Policy D-478.990, "Clinical Information Technology Assistance"
Our AMA will seek a full refundable federal tax credit or equivalent financial mechanism to indemnify physician practices for the cost of purchasing and implementing clinical information technology, including electronic medical record systems, e-prescribing and other clinical information technology tools, in compliance with applicable safe harbors.

Policy D-478.996, "Information Technology Standards and Costs"
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.

Policy D-480.970, "Access and Equity in Telemedicine Payments"
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined shortage areas, if that area can show a shortage of those physician specialists.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-19

Subject:	Inappropriate Use of CDC Guidelines for Prescribing Opioids (Resolution 235-I-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) referred the second resolve of alternate Resolution 235, "Inappropriate Use of CDC Guidelines for Prescribing Opioids." The second resolve in the alternate resolution asked:

> [T]hat our AMA actively continue to communicate and engage with the nation's largest pharmacy chains, pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy in opposition to communications being sent to physicians that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care.

This report provides an update on those communications, highlights complementary AMA advocacy and provides recommendations.

DISCUSSION

The nation's opioid epidemic has led to extensive policy development in multiple areas—from several hundred new state laws and regulations to hundreds of millions of dollars earmarked by federal legislation for treatment of opioid use disorder, harm reduction efforts and other initiatives. Debating the merits of the new laws and regulations would go beyond the scope of this report, but it should be noted that each new law or regulation occurred within a notice and comment period as well as extensive public debate informed by stakeholder advocacy that underpins the lawmaking process. Medical societies may not have supported each piece of legislation or agreed with the regulatory agencies charged with rulemaking, but organized medicine has been an active participant in every state, in Congress and with the relevant federal agencies.

That is not, however, the only type of policymaking that has occurred. Health insurance companies, national pharmacy chains and pharmacy benefit management companies (PBMs) all have—to varying degrees—implemented their own policies governing physician prescribing of controlled substances as well as patients' abilities to have a controlled substance prescription dispensed to them. The result of this type of quasi-regulation is incredibly difficult to quantify on a large scale basis due to the lack of transparency in the public sphere, but the AMA and many medical societies

continue to receive concerns from physicians and patients as to the disruptive nature of health plan, pharmacy chain or PBM interference in the patient-physician relationship. The concern and/or perceived interference has included pharmacists calling to ask about a patient's diagnosis or request patient records, a pharmacist asking for clarification about a prescription or alerting the physician to red flags, a pharmacist recommending a different medication strategy, and in some cases, a pharmacist informing the physician that the prescription will not be filled. This concern and/or interference has even gone so far as a pharmacist demanding patients taper their opioid prescriptions, telling them that the U. S. Drug Enforcement Administration (DEA) identified the patient's prescription as "exceeding the maximum Morphine Milligram Equivalents (MME) as defined by the Centers for Disease Control and Prevention (CDC)."[1] In response to this last incident, the DEA and CDC, among others, stated to the AMA (and the Medical Association of Georgia) that the pharmacist's actions and interpretation of CDC and DEA rules and guidelines were incorrect and inappropriate. MAG informed the AMA of this situation, and the AMA, in turn, reached out to the DEA, CDC, National Association of Boards of Pharmacy and others—all of whom quickly engaged with the AMA to register their disapproval of the pharmacy action and state that they would take all relevant actions in Georgia. Your Board appreciates the fact that DEA, CDC, NABP and others took action to support the concerns of MAG and the AMA.

These different physician-pharmacist interactions, however, are often the inevitable result of policies mainly focused on the dose and/or number of days for a prescription for opioid analgesics. It should be noted at the outset that the AMA strongly supports physicians' efforts to ensure that if a prescription for an opioid analgesic is warranted to help treat a patient's pain, physicians should prescribe the lowest effective dose only for the shortest duration of time. The AMA also supports pharmacists as key partners in helping ensure medication safety and as part of the patient-physician-pharmacist therapeutic triad. The Board and the AMA Opioid Task Force point out that physicians' efforts to make more judicious prescribing decisions have led to a more than 22 percent reduction in retail opioid prescriptions dispensed between 2013-2017, and that these reductions began prior to nearly all legislative, regulatory and other efforts focused on reducing opioid supply.

Concurrent with and despite this progress, national pharmacy chains, health insurance companies and PBMs have implemented their own restrictive opioid prescribing policies. This report will not detail every iteration and difference between the policies except to say that most of the policies are some variation of the "CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016" (the CDC Guideline).[2] In the CDC Guideline's introduction, CDC stated:

> [T]he recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.

Yet, the CDC Guideline goes on to make two recommendations that appear in nearly all the pharmacy, payer and PBM policies:

> [Recommendation] 5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

> [Recommendation] 6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

The AMA is concerned by the fact that policymakers, health plans, corporate pharmacy chains and PBMs have used these recommendations to restrict or refuse patients (with few exceptions) to receive a prescription greater than 90 MME or for more than seven days. It is important to note that CDC Guideline Recommendations 5 and 6 were intended guidelines for acute pain episodes, not a hard threshold, and not intended for chronic pain patients. The U.S. Department of Health and Human Services Interagency Pain Care Task Force draft report commented:

> [A]t least 28 states have enacted legislation related to opioid prescription limits, and many states and organizations **have** implemented the guideline without recognizing that the intended audience was [primary care providers]; have used legislation for what should be medical decision making by healthcare professionals; and have applied them to all physicians, dentists, NPs, and PAs, including pain specialists. Some stakeholders have interpreted the guideline as intended to broadly reduce the amounts of opioids prescribed for treating pain; some experts have noted that the guideline emphasizes the risk of opioids while minimizing the benefit of this medication class when properly managed. The CDC guideline was not intended to be model legislation for state legislators to enact.[3]

Many of the state legislative and other policies enacted and/or implemented since then, however, justify the dosage limit for acute pain based on the CDC Guideline. The HOD addressed this in Policy D-120.932, "Inappropriate Use of CDC Guidelines for Prescribing Opioids." While it is common for state opioid prescribing restriction policies to allow for exceptions for patients with cancer, in hospice or who require palliative care, to name a few, exceptions are highly variable regarding post-operative surgical care, chronic pain, cancer remission-related pain, sickle cell or other conditions for which a patient might require a prescription for a greater dosage than a state law might allow.

AMA has consistently stated its opposition to these hard thresholds because of the potential danger they pose if a patient does not neatly fit into an exception category (e.g., hospice, cancer, palliative care). At the same time, multiple national pharmacy chains implemented some variation[4] of the CDC Guideline as their policy—a move the AMA warned would occur.[5] AMA President Barbara L. McAneny, MD, shared with the HOD at the 2018 Interim Meeting that a pharmacy denied an opioid prescription to one of her prostate cancer patients—claiming he was a drug seeker.[6] Additionally, the AMA "FixPriorAuth" campaign[7] heard from a patient's wife that:

> [T]his happened to my sweetheart, changing insurance companies. He was on pain meds for an extended period and they wouldn't authorize his meds in time so his current prescription ran out and we had to go to the hospital for pain control. They are heartless!!

The AMA's first engagement with this issue dates to discussions that occurred in 2013-2014 with the National Association of Boards of Pharmacy (NABP), the Federation of State Medical Boards (FSMB) and many other stakeholders. Those discussions were born from concerns physicians and others raised with respect to early precursors of opioid prescription restriction policies. The result of those discussions was not only a consensus statement highlighting the legal and professional obligations of physicians, but also the corresponding responsibility of pharmacists.[8]

The AMA's work with the FSMB, moreover, also pre-dated the issuance of the CDC Guideline. One prominent outcome from the FSMB was adoption, in 2017, of an updated "Guidelines for the Chronic Use of Opioid Analgesics."[9] The AMA was a member of the workgroup that provided input to the FSMB during its deliberations and strongly voiced its concern about "one-size-fits-all" thresholds. The FSMB, to its great credit, supported those concerns and the resulting policy reflects support for ensuring patient-focused care. For example, the FSMB states:

> [T]he "focus of the [FSMB] Guidelines that follow is on the general overall safe and evidence-based prescribing of opioids and treatment of chronic, non-cancer pain with the specific limitation and restriction that these Guidelines do not operate to create any specific standard of care, which standard must depend upon fact-specific totality of circumstances surrounding specific quality-of-care events."

In addition to the FSMB's ongoing support for patient-focused care, the development of the NABP consensus statement also resulted in the development of close relationships with pharmacy counterparts at several national chain pharmacies. When issues have arisen in select states where a physician reports a concern with the dispensing decision of a pharmacy, these relationships have enabled AMA to work directly with the national chain and the state medical society to resolve the issue—a resolution based on specific facts rather than a one-size-fits-all approach. The AMA also has remained in close contact with the NABP to share information and work collaboratively where interests align, including efforts to bolster constructive relationships between physicians and pharmacists. It also is worth highlighting that some pharmacy boards are taking steps to remind their licensees about the need to ensure dispensing determinations are made on an individualized patient basis.[10]

Despite continued efforts by AMA to constructively engage Walmart, Inc. (Walmart), however, the national pharmacy chain has taken a markedly different course. Specifically, Walmart has sent an unknown number of what can be considered "blacklist" letters to physicians. These unsigned letters from Walmart's corporate headquarters have been sent in multiple states and only include a generic email address for the physician to respond to if the letter was believed to be sent in error. The letter typically states that the physician in question had his or her "prescribing patterns and practices" reviewed and as a result, "[Walmart] determined that we will not be able to continue filling your controlled substance prescriptions." AMA has sent multiple letters, email and voice messages to Walmart opposing its policy and seeking explanation—all without meaningful response.[11] Others, including the Texas Medical Association, also have not received a meaningful response from Walmart.[12] In one instance, the overly broad and vague Walmart policy targeted a rural Idaho addiction medicine physician who prescribed buprenorphine, but did not prescribe opioid analgesics. As CDC has stated, buprenorphine for the treatment of opioid use disorder should not be used in an MME calculation,[13] but resolution of this matter required extensive commitment from the Idaho Medical Association and Idaho Board of Pharmacy—and resulted in patients being forced to find alternate pharmacies to continue their care.

With respect to health insurance companies, the AMA has made inquiries but is not aware of any widespread action by payers to send physicians letters or other communication "that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances would support such prescribing as falling within standards of good quality patient care." Rather, AMA is acutely aware of health insurance companies implementing hard-threshold guidelines based on the CDC guideline.

AMA President-elect and Chair of the AMA Opioid Task Force, Patrice A. Harris, MD, MA, raised concerns about these payer policies directly to the National Association of Insurance Commissioners (NAIC) at its Regulatory Framework Task Force hearing on Saturday, March 24, 2018. AMA Chair Jack Resneck, Jr., MD, raised similar concerns about patients facing restrictions on receiving opioid analgesics without payers removing prior authorization and other restrictions on non-opioid behavioral, restorative, surgical and other non-opioid modalities at the November 16, 2018 hearing of the NAIC Health Insurance and Managed Care Committee. Both Drs. Harris and Resneck highlighted patients' need for greater access to comprehensive, multidisciplinary, multimodal pain care. The AMA has continued this advocacy directly to state regulators—a primary feature of new, spotlight analyses of state responses to the opioid epidemic.[14]

AMA POLICY

The AMA has extensive and wide-ranging policy in support of ensuring patients receive optimal pain care and removal of arbitrary restrictions on the provision of that care. This includes having AMA "oppose legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence-based, comprehensive pain care. (Policy H-95.930, "Legislative Pain Care Restrictions"). It also includes AMA's "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," as well as the AMA's "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." (Policy D-160.981, "Promotion of Better Pain Care"). AMA policy also supports "the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution." (Policy H-120.960, "Protection for Physicians Who Prescribe Pain Medication"). As noted above, AMA policy supports ensuring that patients are not harmed by the "misapplication of the CDC Guideline for Prescribing Opioids for Chronic Pain by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia." (Policy D-120.932, "Inappropriate Use of CDC Guidelines for Prescribing Opioids").

RECOMMENDATIONS

The Board recommends that the following recommendations be adopted in lieu of the second resolve of alternate Resolution 235-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support balanced opioid-sparing policies that are not based on hard thresholds, but on patient individuality, and help ensure safe prescribing practices, minimize workflow disruption, and ensure patients have access to their medications in a timely manner, without additional, cumbersome documentation requirements. (New HOD Policy)

2. That our AMA oppose the use of "high prescriber" lists used by national pharmacy chains, pharmacy benefit management companies or health insurance companies when those lists do not provide due process and are used to blacklist physicians from writing prescriptions for controlled substances and preventing patients from having the prescription filled at their pharmacy of choice. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Undated letter from Lakeside Pharmacy, "Opioid Therapy Above the MME." On file with author.
[2] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1
[3] U.S. Department of Health and Human Services. Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations. December 2018. Available at https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html#4-review-cdc
[4] See, for example, CVS Caremark® Opioid Quantity Limits Pharmacy Reference Guide. Available at https://www.caremark.com/portal/asset/Opioid_Reference_Guide.pdf
[5] See also AMA January 12, 2016 letter to then-CDC Director Thomas Frieden, MD. Available at https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/cdc-opioid-guidelines-12jan2016.pdf
[6] Attacking the Dysfunction in Health Care. Barbara L. McAneny, MD, President, American Medical Association. AMA Interim Meeting, National Harbor, MD, November 10, 2018. Available at https://www.ama-assn.org/system/files/2018-11/i18-mcaneny-speech.pdf
[7] Physicians and patients can learn more about American Medical Association advocacy to broadly address prior authorization issues at www.FixPriorAuth.org
[8] See "NABP Collaborates With Health Care Stakeholders on Ensuring Delivery of Responsible and Effective Patient Care," February 4, 2014. Available at https://nabp.pharmacy/nabp-collaborates-with-health-care-stakeholders-on-ensuring-delivery-of-responsible-and-effective-patient-care/
[9] Guidelines for the Chronic Use of Opioid Analgesics Adopted as policy by the Federation of State Medical Boards April 2017. Available at https://www.fsmb.org/siteassets/advocacy/policies/opioid_guidelines_as_adopted_april-2017_final.pdf
[10] See, for example, a January 23, 2019 letter from the Alaska Board of Pharmacy stressing, among other things, that "Simply refusing to fill a prescription without trying to resolve the concern may call into question the knowledge, skill or judgment of the pharmacist and may be deemed unprofessional conduct." The full letter is available at https://www.commerce.alaska.gov/web/portals/5/pub/pha_ControlledSubstanceDispensing_2019.01.pdf
[11] See August 16, 2018 AMA letter to Walmart at https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-8-16-McMillon-Hays-Walmart-Opioid-Policy-letter.pdf; and October 3, 2018 AMA letter to Walmart: https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-10-3-Letter-to-Walmart-FINAL.pdf
[12] "Opioid Overreach? State, Retail Pharmacy Policies Prompt Scope-of-Practice Concerns," Texas Medicine, December 2018. Available at https://www.texmed.org/Template.aspx?id=49157
[13] January 4, 2018 letter from Debra Houry, MD MPH Director, National Center for Injury Prevention and Control Centers for Disease Control and Prevention, to the American Society of Addiction Medicine. Available at https://www.asam.org/docs/default-source/advocacy/letters-and-comments/2018-1-4-letter-on-buprenorphine-and-cdcs-guideline-(002).pdf?sfvrsn=7fa840c2_2
[14] The spotlight analyses can be found on the AMA's opioid microsite. The Pennsylvania spotlight is available at https://www.end-opioid-epidemic.org/wp-content/uploads/2018/12/AMA-Manatt-PAMED-spotlight-analysis-FINAL-for-release.pdf and the Colorado spotlight is available at https://www.end-opioid-epidemic.org/wp-content/uploads/2019/01/AMA-Paper-Spotlight-on-Colorado-January-2019_FOR-WEB.pdf

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-19

Subject:	Prior Authorization Requirements for Post-Operative Opioids (Resolution 208-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 208-A-18, "Prior Authorization Requirements for Post-Operative Analgesia," introduced by the Pennsylvania Delegation, which asked:

> That our American Medical Association strongly oppose prior authorization requirements for postoperative analgesia equivalent to five days or less so as to prevent patient suffering.

Reference committee testimony generally was supportive of the original resolution given physicians' and patients' experiences with legislative and other policies focused on hard thresholds for opioid prescribing post-surgery and other acute care settings. Yet, there was concern raised regarding taking a position to oppose all prior authorization or other utilization management protocols. The AMA Council on Medical Service and Council on Legislation were among those who asked that our Board take this resolution back for consideration, discussion and present clear recommendations to further the intent of the original resolution.

DISCUSSION

There are multiple, competing and often contradictory trends that define the nation's opioid epidemic. Opioid-related mortality continues to increase, but data from the Centers for Disease Control and Prevention (CDC)[1] show that the nation's opioid overdose and death epidemic continues to be driven by increases in death due to illicit fentanyl. Deaths due to prescription opioid- and heroin-related causes appear to have plateaued but remain at historic highs. In 2017:

- 28,466 died from illicit fentanyl-related overdose (19,413 in 2016).
- 15,482 died from heroin-related overdose (15,469 in 2016).
- 14,495 died from prescription opioid-related overdose (14,487 in 2016). (More than 60 percent of people who misused prescription opioids steal them or obtain them from a family member or friend.[2])
- 3,194 died from methadone-related causes—the lowest number since 2003. (The data does not distinguish whether methadone was used for pain or for the treatment of opioid use disorder.[3])

At the same time, opioid prescribing in the United States continues to decrease. Between 2013-2017, retail filled opioid prescriptions decreased by 22.2 percent with a total of 196 million opioid

prescriptions filled in 2017.[4] Decreases occurred in every state. The most common opioid prescription was for less than 30 days and less than 50 morphine milligram equivalents (MME). From 2014 to 2016, opioid prescriptions written for fewer than 30 days decreased from 150.4 million to 126.5 million; and opioid prescriptions of less than 50 MME decreased from 175.6 million in 2014 to 158.0 million in 2016.[5]

Policymakers for the past several years have focused almost entirely on mandating a few specific policies or approaches that they believe would help end the epidemic. These include enacting legislation in nearly four out of five states to require physicians to use a state prescription drug program (PDMP); mandating content-specific continuing medical education (CME) in more than half of the states; and prohibiting a prescription for an opioid analgesic if it is greater than a certain number of days or for a greater than a certain MME.

Restrictions on opioid prescribing also have been implemented by health plans, national pharmacy chains and pharmacy benefit management companies.[6] Many of these policies follow the publication from the CDC entitled, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (the Guideline)."[7] In the Guideline's introduction, CDC stated:

> The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.

Many of the state legislative and other policies enacted and/or implemented since then, however, justify the day/dose limit for acute pain based on the CDC Guideline. The HOD addressed this in Policy D-120.932, "Inappropriate Use of CDC Guidelines for Prescribing Opioids." And while it is common for state opioid restriction policies to allow for exceptions for patients with cancer, in hospice or who require palliative care, to name a few, there generally is no exception for when post-operative surgical care might require a prescription for a greater number of days or dose strength than a particular state might allow.

State policymaking also has resulted in no consistency between opioid restriction or other laws. For example, some states require checking the PDMP prior to prescribing any controlled substance or limited to only opioid analgesics. Other states require a PDMP check every 90 days (or another interval) for repeated prescriptions, and other states require a check only once per year. With respect to CME mandates, the number of hours and specific nature of the CME vary by state. The Board notes that the AMA Opioid Task Force has gathered more than 400 state- and specialty-specific resources to help promote the availability of education and training that is relevant and meaningful to a physician's specific practice and patient population.[8] The Board thanks all those Federation partners who have contributed to this effort.

With respect to opioid prescribing, physicians and other prescribers of controlled substances have borne a considerable amount of blame. The AMA and countless physician organizations have accepted responsibility for both working to reduce patients' pain and the medical community acknowledges its role in having in the past increased opioid prescribing as one way to help alleviate patients' pain. The AMA also has supported efforts by law enforcement and others to stop illegal activities such as pill mills and the AMA and countless physician organizations have made considerable progress in urging physicians to be more judicious in their prescribing decisions as the above data show. The Board knows, however, that there is much more work to do before the epidemic will end.

The AMA continues to stress the need for evidence-based decision making on the part of policymakers with respect to restrictions on opioid prescribing. Given that state policies have been the result of political negotiations rather than scientific evidence, it is possible that a course correction could be made. One such direction could be to follow the patient-centric recommendations of the U.S. Department of Health and Human Services, "Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations,"[9] which includes among its many positive recommendations, support for:

- Individualized treatment as the primary goal of acute pain management, accounting for patient variability with regard to factors such as comorbidities, severity of conditions, surgical variability, geographic considerations, and community/hospital resources.
- Improved pain control, faster recovery, improved rehabilitation with earlier mobilization, less risk for blood clots and pulmonary embolus, and mitigation of excess opioid exposure.

Similarly, as physicians continue to play a leading role in reducing opioid prescriptions and advocating for patients' access to opioid analgesics when appropriate, there is a great need to remove prior authorization for multidisciplinary and multimodal pain care, including non-opioid alternatives. This has been one of the central findings of AMA spotlight analyses of efforts in the Medicaid agencies of several states,[10] but the AMA also continues to hear regularly from physicians about commercial health insurance companies who resist removing prior authorization hurdles as well as their limited efforts to increase access to non-opioid alternatives. The Board strongly recommends that health insurance companies work with physicians and the nation's medical societies to remove barriers to non-opioid pain care.

There are good examples in the pain stewardship and other comprehensive pain care programs that have been implemented in many areas of the country. This includes programs at Kaiser Permanente, Geisinger Health System, Intermountain Health Care and the University of Chicago, to name a few. There also continues to be emerging research focusing on the most appropriate length and dose of an opioid prescription post-operatively. This includes for procedures ranging from rhinoplasty,[11] gynecologic and abdominal surgery,[12] care delivered in the emergency department,[13] as well as mastectomy, general surgery and musculoskeletal procedures.[14]

There generally are three common elements to these efforts by systems and researchers. First, they all have engaged in extensive data review to determine what baseline of opioid prescribing was taking place in the system and for the specific procedures. Second, they all discovered that while opioid prescribing overall could be reduced, none put a hard threshold on the amount given post-operatively or following an acute care episode. And third, even when guidelines were established for physicians, those guidelines provided a range rather than a single number. In the systems, furthermore, and as noted above in Medicaid, there is increasing realization that while opioid sparing protocols may be beneficial, patients must not be left without sufficient forms of pain care. That is, opioid reductions may have occurred, but the focus for these physicians has been on improving patient outcomes.

AMA POLICY

AMA has extensive policy supporting the principle that utilization management policies, clinical practice guidelines and clinical quality improvement activities must be based on sound clinical evidence, data and allow for variation based on individual patient needs (e.g., Policy H-320.949, Clinical Practice Guidelines and Clinical Quality Improvement Activities). AMA policy also promotes patient access to comprehensive, multidisciplinary, multimodal pain care, including working with all stakeholders to promote research and develop evidence to support quality pain

care. This includes promoting safe opioid prescribing and promoting a public health approach to ending the nation's opioid epidemic (e.g., Policy D-160.981, Policy H-95.990, "Promotion of Better Pain Care and Drug Abuse Related to Prescribing Practices"). And, it includes AMA strong support for "timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care." (Policy D-450.956, "Pain as the Fifth Vital Sign.") It should also be stressed that AMA's efforts to reduce prior authorization burdens and protect patients' access to medically necessary therapy extend far beyond only post-operative pain care (e.g., Policy H-320.939, "Prior Authorization and Utilization Management Reform" and the grassroots advocacy campaign based on the online hub, FixPriorAuth.org).

RECOMMENDATIONS

The Board recommends that the following recommendation be adopted in lieu of Resolution 208-A-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for state legislatures and other policymakers, health insurance companies and pharmaceutical benefit management companies to remove barriers, including prior authorization, to non-opioid pain care. (New HOD Policy)

2. That our AMA support amendments to opioid restriction policies to allow for exceptions that enable physicians, when medically necessary in the physician's judgment, to exceed statutory, regulatory or other thresholds for post-operative care and other medical procedures or conditions. (New HOD Policy)

3. That our AMA oppose health insurance company and pharmacy benefit management company utilization management policies, including prior authorization, that restrict access to post-operative pain care, including opioid analgesics, if those policies are not based upon sound clinical evidence, data and emerging research. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 30-A-19

Subject:	Opioid Treatment Programs Reporting to Prescription Monitoring Programs (Resolution 507-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

INTRODUCTION

At the 2018 American Medical Association (AMA) House of Delegates (HOD) Annual Meeting, the Medical Student Section introduced Resolution 507-A-18, asking that our AMA amend Policy D-95.980, "Opioid Treatment and Prescription Drug Monitoring Programs," by deletion as follows:

> Our AMA will seek changes to ~~allow states the flexibility to~~ require opioid treatment programs to report to prescription monitoring programs.

The resolution was ultimately referred. There was considerable testimony at the reference committee identifying numerous issues to both support and oppose the resolution. This report provides a current update of prescription drug monitoring programs (PDMPs), the privacy protections patients are afforded with respect to PDMPs, relevant federal laws governing opioid treatment programs (OTPs), highlights relevant AMA policy, and presents a recommendation.

DISCUSSION

Prescription drug monitoring programs

PDMPs are generally described as electronic interfaces that allow physicians and other authorized users to view a patient's-controlled substance prescription history. Every state except Missouri has a PDMP, although some are more advanced than others. The AMA supports physicians registering for and using PDMPs as part of the clinical decision-making process.

At present, at least 44 states require physicians and other clinicians who prescribe controlled substances to query the PDMP under certain circumstances. These mandates range from requiring a query prior to prescribing any controlled substances every time a prescription for a controlled substance is issued to every six months or a year; to queries limited only to the prescribing of opioid analgesics and benzodiazepines.

Emerging data suggests that PDMPs have not led to reductions in opioid-related mortality as proponents have predicted. From 2014 and 2017, physicians' and other health care professionals' use of PDMPs increased from 61.4 million queries to more than 300.3 million queries; and registration to use a PDMP increased from 471,896 to more than 1.5 million registered users.[1] Opioid-related mortality, however, has increased considerably. From 2012 to 2017, prescription opioid-related mortality increased from 11,134 to 14,495; heroin-related mortality increased from

5,925 to 15,482; and illicit fentanyl-related mortality increased from 2,628 to 28,466. Meanwhile, there remains an unacceptable treatment gap for those with a substance use disorder (SUD) or co-occurring mental illness. According to the 2017 National Survey on Drug Use and Health (NSDUH) conducted by the U.S. Substance Abuse and Mental Health Services Administration, 92.3 percent of those age 12 and older received no treatment for an SUD; and 91.7 percent of those 18 and older received no treatment for a co-occurring mental illness and SUD.[2]

Evaluation of PDMPs before 2012 found mixed results with respect to PDMP effects on opioid prescribing, reductions in morphine milligram equivalents (MME), per-capita opioid prescribing, mortality rates, and opioid-related admissions to the emergency department.[3] A more recent, comprehensive study found that "PDMPs were not associated with reductions in drug overdose mortality rates and may be related to increased mortality from illicit drugs and other, unspecified drugs."[4] A prospective look at how PDMPs can impact the nation's opioid epidemic found that "interventions such as prescription drug monitoring programs are unlikely to lead to major decreases in the number of deaths from opioid overdose in the near future."[5] These studies are not to suggest there is no role for PDMPs or that there is no other data showing positive effects of PDMPs—rather, that an overreliance on PDMPs to solve the nation's opioid epidemic will not likely lead to widespread, positive impacts.

PDMPs and privacy protections

The AMA *Code of Medical Ethics* (the Code) states that "Protecting information gathered in association with the care of the patient is a core value in health care." The Code further states that

> Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient.

In a recent letter to the United States Office of Civil Rights,[6] the AMA stated that

> [t]he first step of any ultimately successful privacy framework, legislative or regulatory, places the patient first. Each entity seeking access to patients' most confidential medical information must pass the stringent test of showing why its professed need should override individuals' most basic right in keeping their own information private—something that technology can help physicians accomplish in a minimally burdensome way. Moreover, citizens deserve a full and open discussion of exactly who wants their private medical information and for what purpose. Only then may the true balancing of interests take place. These are the ground rules of AMA policy and they should be the ground rules for the federal debate regarding data privacy.

With respect to PDMPs, the AMA has significant privacy concerns about law enforcement and other non-health care entities using a PDMP because of the personal health information (PHI) contained within a PDMP. PHI may include a patient's controlled substance prescription history, which can potentially cause someone to learn a patient is being treated for gender dysphoria, a substance use disorder, mental illness, HIV/AIDS or other medical condition that has historically been subject to stigmatization. The AMA believes that an appropriate balance between law enforcement access and a patient's right to privacy occurs when law enforcement obtains a court-issued warrant or other judicially authorized access. That occurs, however, in fewer than 20 states.[7] Only four states have granted authority for third-party payers other than Medicaid access to PDMPs[8] despite third-party payer state legislative efforts.

In the courts, the AMA and nine state medical societies argued to the Ninth Circuit Court of Appeals against the United States Drug Enforcement Administration efforts to access the Oregon PDMP with only an administrative warrant that "patients have a basic right to privacy of their medical information. That privacy should be honored unless there is meaningful waiver by the patient or a strong countervailing public health or safety interest, and then only with stringent safeguards."[9] The AMA and California Medical Association also argued against unfettered access to patients' prescription information in *Lewis v. Medical Board of California*, where "a Medical Board of California investigator testified that the board routinely obtains confidential prescribing records from [the California PDMP] for all patients of physicians subject to medical board investigations, even where the complaint is unrelated to the patients or the physician's prescribing practices."[10]

Additionally, before enacting a law requiring that police and prosecutors obtain warrants before searching in sensitive patient information in the state's prescription monitoring database, Massachusetts allowed police and prosecutors to view patient medical records without warrants nearly 11,000 times—or about 20 times per day—between August 2016 and March 2018.[11]

Unauthorized access also can occur when law enforcement inappropriately pressures pharmacists to query a PDMP without judicial oversight. The American Pharmacists Association counsels that:

> The information in PDMP reports is personal and private. Patients expect that pharmacists will maintain the confidentiality of this information, and this is a key aspect of the professional relationship of trust between pharmacists and patients.[12]

Unauthorized access and inappropriate use of an individual's person health information can have devastating effects, such as occurred to a Utah firefighter whose PDMP information was accessed and misinterpreted at multiple steps during several year long legal battle. Ultimately, all charges were dismissed, but not before the damage had been done.[13]

Notwithstanding the legal requirements, case law and news items noted above, states generally have strong protections regarding the unauthorized use of information within a PDMP. While important work is being done to remove stigma and regard SUD as a medical condition like any other, the fact remains that illicit substance use is illegal, which is decidedly unlike any other medical issue.[14] Inappropriate disclosure of SUD data can result in consequences exponentially more harmful to a patient than the improper disclosure of his or her hypertension (e.g., loss of housing,[15] loss of child custody,[16] discrimination from medical professionals,[17] loss of benefits[18] or loss of employment,[19] among others).[20] Any discussion of increasing the exchange of SUD information must contemplate the potential for such outcomes.

The AMA supports the refinement of PDMPs and development and implementation of technology that assists physicians with sharing information on prescriptions for controlled substances among states. AMA also calls for appropriate balance when the information in question relates to patients who receive treatment in an OTP—patients who often experience a much higher degree of stigmatization and prejudice than other patients with a chronic medical disease.

Further, even if a patient receiving care in an OTP authorized the disclosure of prescription information to be entered into a PDMP, it is unclear how that authorization would protect the patient against further re-disclosure. That is, proponents of removing OTP privacy and disclosure protections suggest that the PDMP already has sufficient safeguards against unauthorized use, but as noted above, that is not actually the reality. In addition, the patient privacy and consent provisions of relevant federal law (often referred to as Part 2) allow for a case-by-case

determination by the patient to whom disclosure may be made. Thus, while the patient may authorize and provide specific consent for disclosure to other health care professionals who treat the patient, *any* authorized user of a PDMP could view the OTP patient's prescription history once it is entered into the PDMP. Until a PDMP has much more advanced controls and sufficient privacy protections for OTP users, entering a patient's prescription history into the PDMP would almost certainly mean widespread disclosure well beyond those involved in the patient's care.

It should further be emphasized that Part 2 written consents prohibit the recipient from further disclosure of the information. In other words, it would be neither operationally feasible nor legally logical to send information to a PDMP—the PDMP would not be allowed to redisclose it to anyone, regardless of whether they are authorized to access the PDMP, absent additional written patient consent. That is key because PDMPs are not set up to prevent re-disclosure. As explained at the outset of this report, they are databases that contain considerable information and can be accessed by any authorized user.

OTPs and PDMPs

Part 2 does not permit information about a patient in an OTP to be entered into the PDMP without the patient's specific consent, even if the OTP dispenses medication. The rationale for this rule is that identifying individuals with an SUD could lead to discrimination against the individual, and part of the original purpose of Part 2 was a decision by lawmakers to promote and protect individuals seeking SUD treatment. The AMA supports this rationale and has heard from front line clinicians who agree that identifying patients who receive SUD treatment could have a chilling effect on patients seeking care.

Adopting policy that requires OTPs to report to PDMPs would necessitate a change to the statute underlying Part 2. Most stakeholders who support such a change want OTPs (and other practice settings to which Part 2 applies) to disclose information in accordance with the Health Insurance Portability and Accountability Act (HIPAA)—that is, in a less-restricted manner. HIPAA allows disclosure of a patient's health information without a patient's consent for treatment, payment and health care operations (TPO) purposes, as defined by HIPAA. Purportedly, to address concerns that patients will maintain control over how their information is shared, proponents of changing Part 2 to allow OTPs to enter information into PDMPs claim that patients diagnosed with an SUD will still have the "same consent requirements" when his or her information is disclosed for TPO purposes as any other patient does under HIPAA. However, while patients *may be asked* for consent to share their information for TPO purposes under HIPAA, *patient consent is not required*.[21] This is a critical distinction, and if Part 2 is changed, would immediately change patients' privacy protections for the hundreds of thousands of patients currently receiving care in an OTP.

Changing Part 2 to require OTPs to report to PDMPs would effectively remove the very privacy protections that were created to encourage SUD treatment. Indeed, 113 patient advocacy groups have stated that such a change will discourage individuals struggling with addiction from seeking treatment if they know that their information will not be protected.[22] The 2017 NSDUH reported that among the top reasons for those with an SUD not receiving treatment: "Might Cause Neighbors/Community to Have Negative Opinion;" "Might Have Negative Effect on Job;" and "Did Not Want Others to Find Out."[23] At a time when the nation's opioid epidemic is worse than ever, policymakers must balance greater access to information with potential effects of undermining patient privacy when attempting to increase access to care. Given the lack of data showing the benefits of additional information or use of the PDMP to mitigate the epidemic's harms, the AMA believes that the balance clearly edges toward patient privacy as opposed to

opening the door to adverse effects on patients who receive—or might be deterred from seeking—care in an OTP.

AMA POLICY

AMA policy strongly supports patient privacy and confidentiality protections in all areas of health care. This includes calling for "safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred" (Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality"). AMA policy also makes clear that the AMA "considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information" (Policy H-95.945, "Prescription Drug Diversion, Misuse and Addiction"). The AMA also "supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program." (Policy H-95.927, "Universal Prescriber Access to Prescription Drug Monitoring Programs"). Despite the impression given by the title of the policy, the AMA broadly supports physicians using PDMPs only "when clinically appropriate" as well as sharing information "within the safeguards applicable to protected health information." AMA policy also calls for using PDMPs as part of the effort to identify and reduce "multiple provider events" that can occur when patients receive multiple controlled substance prescriptions from multiple pharmacies or other dispensers in a short time frame to help ensure continuity of care." (Policy H-95.928, Model State Legislation "Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing").

Finally, as noted throughout this report, AMA policy regarding patients' rights to privacy and confidentiality of their personal health information is robust. (Policy H-315.983, "Patient Privacy and Confidentiality"). A strong, representative sample includes provisions that state:

> there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; 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.

It goes on to state that in such instances that "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." Finally, AMA Policy H-315.983, "Patient Privacy and Confidentiality," states that:

> 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," and that "[t]he 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.

RECOMMENDATION

The Board of Trustees recommends that Resolution 507-A-18 not be adopted and the remainder of this report be filed.

Fiscal Note: Less than $500.

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[9] *Oregon Prescription Drug Monitoring Program, ACLU Foundation Of Oregon, Inc., et al., v. United States Drug Enforcement Administration*. AMA amicus brief available at https://searchltf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fcasebriefs%2Foregon-pdmp-v-dea.pdf. The medical societies joining the AMA were the Oregon Medical Association, Alaska State Medical Association, Arizona Medical Association, California Medical Association, Hawaii Medical Association, Idaho Medical Association, Montana Medical Association, Nevada State Medical Association and the Washington State Medical Association.

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[17] https://www.ncbi.nlm.nih.gov/pubmed/23490450

[18] https://www.ssa.gov/policy/docs/rsnotes/rsn2001-02.html

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[20] http://www.healthaffairs.org/do/10.1377/hblog20170413.059618/full/; see also https://www.macpac.gov/wp-content/uploads/2018/06/Substance-Use-Disorder-Confidentiality-Regulations-and-Care-Integration-in-Medicaid-and-CHIP.pdf, p. 25.

[21] 45 CFR 164.506(b)(1).

[22] https://lac.org/112-nations-leading-patient-advocacy-health-care-organizations-launch-campaign-protect-patient-privacy-rights/

[23] See Table 5.54B – Detailed Reasons for Not Receiving Substance Use Treatment in Past Year among Persons Aged 18 or Older Classified as Needing But Not Receiving Substance Use Treatment at a Specialty Facility and Who Felt a Need for Substance Use Treatment in Past Year: Percentages, 2017. National Survey on Drug Use and Health. Available at https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab5-46A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-19)

Introduced by: American Society of Transplant Surgeons

Subject: Assuring Patient Access to Kidney Transplantation

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Kidney transplantation is often the best and most cost-effective treatment for patients with End Stage Renal Disease (ESRD); and

Whereas, Some for-profit health-care entities have sought to remove control of kidney transplantation decision-making from many physicians and their patients[1]; and

Whereas Some for-profit health care entities have sought to create monetary incentives that would sharply curtail patient access to transplantation; and

Whereas, There exists comprehensive patient-oriented care models such as the Centers for Medicare and Medicaid Innovation Comprehensive ESRD Care Model[2] that do not threaten access to transplantation; and

Whereas, Dialysis and transplant professional[3-5] as well as patient-centered groups[5,6] oppose limitations on physician-advised patient choice of kidney transplantation in ESRD treatment; therefore be it

RESOLVED, That our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further

RESOLVED, That our AMA actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions (Directive to Take Action); and be it further

RESOLVED, That our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to organ transplantation (Directive to Take Action); and be it further

RESOLVED, That our AMA House of Delegates be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

1 Dialysis PATIENTS Demonstration Act of 2017" (S. 2065) (HR 4143): https://www.congress.gov/bill/115th-congress/house-bill/4143/text
2 Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model: https://innovation.cms.gov/initiatives/comprehensive-esrd-care/

3 American Society of Transplant Surgeons: The ASTS-AST-AOPO-AAKP Joint Letter on Dialysis PATIENTS Demonstration Act of 2017: https://asts.org/docs/default-source/legislative/joint-letter-on-the-house-patients-act-december-1-2017.pdf?sfvrsn=94227ed3_2
4 DCI: Letter 2 November, 2017: http://asts.org/docs/default-source/test-document-library/dci-h-r-4143-letter-11-02-17.pdf?sfvrsn=83987fd3_2
5 American Association of Kidney Patients and the American Society of Nephrology: Letter 28 February, 2018: http://asts.org/docs/default-source/test-document-library/asn-aakpletter-patientact-housesenate_2018-2-18.pdf?sfvrsn=82987fd3_4
6 The FAIR Foundation: www.FAIRfoundation.org : Policy adopted 28 January, 2018

RELEVANT AMA POLICY

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

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.
Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-19)

Introduced by: California

Subject: Reducing the Hassle Factor in Quality Improvement Programs

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The Center for Medicare and Medicaid Services (CMS) is soliciting suggestions for improving the current Merit-Based Incentive Payment System (MIPS) in the Quality Payment Program (QPP) to reduce administrative burdens as part of their "Patients Over Paperwork" Initiative; and

Whereas, Physicians are asked to participate in Certification/Maintenance of Certification by the American Board of Medical Specialties (ABMS) including the American Board of Internal Medicine (ABIM); and

Whereas, The CMS-stated goal of MIPS is to improve quality of care and the MOC program goals are to maintain and improve quality of care with emphasis on knowledge base, and

Whereas, Both MIPS and MOC take a significant amount of time away from patient care, and have increased the administrative burden and stress on the practicing physician; and

Whereas, Our AMA, the state medical associations, and the national specialty societies all agree on the importance of reducing the hassle factor for physicians; therefore be it

RESOLVED, That our American Medical Association recommend to the Centers for Medicare and Medicaid Services (CMS) and physician certifying boards, such as the American Board of Medical Specialties, that maintenance of certification (MOC) participation count toward satisfying the quality category of the Merit-Based Incentive Payment Program (MIPS) (Directive to Take Action); and be it further

RESOLVED, That our AMA also recommend that successful reporting in the quality category of the Merit-Based Incentive Payment Program (MIPS) count toward satisfying the practice performance assessment section of a certifying board's MOC requirements) (Directive to Take Action); and be it further

RESOLVED, That our AMA study MOC and Medicare MIPS reciprocity and work with the state and national specialty societies to develop a plan to reduce quality measure duplication and administrative burdens in both the MIPS and MOC programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/29/19

RELEVANT AMA POLICY

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.
38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.
39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education’s annual report on maintenance of certification at the 2019 Annual Meeting.
Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Citation: Res. 208, I-16; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.
Citation: Res. 236, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-19)

Introduced by: California

Subject: Medicare Part B and Part D Drug Price Negotiation

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, In 2016, total prescription drug spending reached $328 billion, more than double what was spent in 2002 and physicians are concerned that patients cannot afford necessary medications that will improve their health; and

Whereas, One in four patients report that they or another family member did not fill a prescription in the last year because of cost. One in four patients with cancer are choosing not to fill a prescription or are taking less due to cost; and

Whereas, Prices for commonly used brand name drugs increased 164% and Medicare Part D spending doubled over the last decade; and

Whereas, Under the current Medicare program, drug manufacturers set the price for Medicare Part D and Part B prescription drugs while all other providers (physicians, hospitals, home health, nursing homes) are subject to a government fee schedule; and

Whereas, According to an analysis published in *JAMA Internal Medicine*, if Medicare Part D paid prices for prescription medications similar to what the Department of Veterans Affairs pays, there could be an estimated annual savings of 38-50% because the VA has the ability to directly negotiate with pharmaceutical manufacturers; and

Whereas, Under Medicare Part B, a pharmaceutical manufacturer can charge physicians as much as it wants for physician-administered drugs--unconstrained by any fee schedule or price limits. Moreover, physicians do not have access to the discounted drug prices that pharmacies and health plans enjoy, which make these drugs more costly; and

Whereas, Many policy-makers are considering proposals to make it more difficult for physicians to provide important Medicare Part B medications in their offices; and

Whereas, Medicaid is authorized to negotiate best prices for drugs and thus, allowing Medicare to negotiate drug prices with drug-makers would make a meaningful difference in controlling costs in both the Medicare program and the private sector; and

Whereas, According to the Centers for Disease Control and Prevention (CDC), about 500,000 Americans age 60 and older get shingles (caused by the varicella zoster virus) every year. Individuals aged 60 and older are vulnerable to certain diseases that could be prevented by vaccines; and

Whereas, Both the Medicare Part D and Part B programs have made it difficult for physicians to administer and patients to gain access to important vaccines; and

Whereas, Elderly patients should have the choice of receiving important vaccines and other medications in their physicians office, thereby allowing physicians to efficiently provide comprehensive care, particularly to those high-risk, chronically-ill patients; therefore be it

RESOLVED, That our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs (Directive to Take Action); and be it further

RESOLVED, That our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare and Medicaid Services for Medicare Part D and Part B covered drugs (Directive to Take Action); and be it further

RESOLVED, That our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician's office. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/29/19

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices. Citation: (BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11

Financing of Adult Vaccines: Recommendations for Action H-440.860
1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:
Provider-related
a. Develop a data-driven rationale for improved vaccine administration fees.
b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
c, Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.

d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.
Federal-related
a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.
State-related
a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.
Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
c. Improve accountability by adopting performance measurements.
d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).
Manufacturer-related
Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.
3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.
Citation: (CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17

Cuts in Medicare Outpatient Infusion Services D-330.960
1. Our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services.
2. Our AMA will continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.
Citation: Res. 926, I-03; Reaffirmed and Modified: CMS Rep. 3, I-08; Reaffirmation A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: I-18

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904
1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
Citation: Res. 241, A-16

Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933
Our AMA will:
a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.
Citation: (Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-19)

Introduced by: California

Subject: Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The ongoing opioid epidemic in the United States has been labeled a public health crisis by the President of the United States, with significant attendant financial costs to hospitals, health systems, insurers, communities, families, patients, and many others; and

Whereas, It has been alleged that the pharmaceutical industry has long promoted overuse of opioids through a wide range of tactics to misbrand and misrepresent the risk of addiction and abuse; and

Whereas, A new NPR/IPSOS poll found that 57% of Americans now say pharmaceutical companies should be held responsible for making the opioid crisis worse. An even larger majority of those polled (70%) said even after companies pay fines and penalties, they should be forced to publicly disclose details of the role they played in fueling the epidemic; and

Whereas, When “big tobacco” was shown to have known of and promoted harmful products, eventual legal action compelled large financial settlements to be distributed to those negatively impacted by their products; and

Whereas, Similar legal actions are now being pursued against pharmaceutical manufacturers around the nation to hold drug-makers accountable and to assist negatively impacted providers, patients and state and local governments; therefore be it

RESOLVED, That our American Medical Association advocate that the relevant pharmaceutical industry organizations be held financially responsible for the health care and other economic costs related to their unethical and deceptive misbranding, marketing, and advocacy of opioids. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/29/19

RELEVANT AMA POLICY

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.
Citation: 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; Reaffirmed: Res. 235, I-18

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.
Citation: BOT Rep. 3, A-08; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16; Appended: BOT Rep. 13, A-17

9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs

Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patientshealth and safety, and compromising patient physician relationships.

In the context of direct-to-consumer advertising of prescription drugs, physicians individually should:

(a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products.

(b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to:

(i) assess and enhance the patients understanding of the test, drug or device;

(ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options.

(c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated.

(d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards.

(e) Deny requests for an inappropriate test, drug, or device.

(f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that:

(i) promotes false expectations;

(ii) does not enhance consumer education;

(iii) conveys unclear, inaccurate, or misleading health education messages;

(iv) fails to refer patients to their physicians for additional information;

(v) does not identify the target population at risk;

(vi) encourages consumer self-diagnosis and treatment.

Collectively, physicians should:

(g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care.

(h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not:

(i) provide a fair and balanced discussion of the use of the drug product for the disease, disorder, or condition;

(ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product;

(iii) present summary information in language that can be understood by the consumer

(iv) comply with applicable regulations;

(v) provide collateral materials to educate both physicians and consumers.

AMA Principles of Medical Ethics: II,III

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-19)

Introduced by: Illinois

Subject: Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Patient or coworker observation experience surveys are increasingly used by healthcare centers in evaluating physician clinical care and are often tied to physician salaries; and

Whereas, These patient surveys focus on patient perspectives and brand management while not addressing any specific quality metrics of complicated clinical care; and

Whereas, Coworker observation metrics have not been validated as a reliable monitoring tool for patient care or clinical professional behavior; and

Whereas, Patient or coworker experience surveys depend upon active responses and thus may exhibit reporting bias due to complaints frequently unrelated to the providers' actual clinical care; and

Whereas, It has been demonstrated that higher patient satisfaction scores are associated with higher health care and prescription expenditures; and

Whereas, Patient satisfaction utilization can promote job dissatisfaction, attrition, and inappropriate clinical care (the very opposite of high-value clinical care); and

Whereas, Patient surveys or coworker observation metrics are not conducted nor evaluated in a peer-review environment; and

Whereas, These surveys and metrics are performed anonymously and thus cannot be adequately addressed by the clinician; and

Whereas, These metrics are usually utilized only to negatively impact an employed physician's salary in a punitive manner (with no potential for positive impact); and

Whereas, A clinician's overall work product cannot be distilled to a few numerical metrics; and

Whereas, Health care centers may publish the results of patient or coworker surveys regarding individual providers in an effort to be "transparent"; and

Whereas, It is apparent that patient satisfaction surveys or coworkers' observation reporting symptoms produce "scores" that are not related to any clinical quality metric, have questionable validity, and are often taken out of context; therefore be it

RESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. “loyalty scores”) or the coworkers’ observation reporting system, and employed physicians’ salaries (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers’ observation reporting system information directed at an individual physician (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-19)

Introduced by: Illinois

Subject: Changing the Paradigm: Opposing Present and Obvious Restraint of Trade

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Many healthcare providers and established, quality-based referral patterns are threatened or already overtaken by monopoly network interests; and

Whereas, Many private and employed physicians' voices are not being heard clearly because of some degree of risk of network exclusion/termination; and

Whereas, Despite the fact that the most valuable part within the network is the group of physicians, large provider systems will continue to commoditize physicians and physician services, and continue to compete on price, negatively impacting the already diminishing and set value share (compensation) of physicians in and out of large networks; and

Whereas, Delivering compassionate and personalized care to a patient is the most agreed-upon interest that we serve, and the foundation of this is a trusting doctor patient relationship, and now increasingly other interests are entering into and compromising this relationship; and

Whereas, Insurance providers and health delivery systems have inadvertently, or intentionally, added incredible levels of "red tape" to true health service; therefore be it

RESOLVED, That our American Medical Association seek legislative or regulatory changes to allow physicians to collectively negotiate professional fees, compensation and contract terms without integration. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-19)

Introduced by: Illinois

Subject: Direct-to-Consumer Genetic Tests

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Direct-to-consumer genetic testing, such as 23andMe and AncestryDNA.com, is publicly promoted and commercially available to bring personal insight into ancestry, genealogy, and inherited traits by means of a genetic blueprint (Personal Genome Service or PGS); and

Whereas, The genetic testing may or may not reveal variants associated with a higher risk of certain diseases such as Alzheimer's, Parkinson's, or Macular Degeneration, which may not have clinical merit, but could result in emotional distress upon discovery; and

Whereas, The PGS is deemed a medical device by the US Food and Drug Administration,[1] but is also a mechanism for massive information-gathering whereby personal, self-disclosed information, including a person's genome, can be used by the company or third parties for selling the consumer products and services; and

Whereas, PGS companies have different policies regarding managing and disseminating information for research purposes, including academic institutions, non-profit foundations, and pharmaceutical companies for journal publications, and some have indicated that their database-sifting scientific work does not constitute research on human subjects[1]; and

Whereas, Some genetic testing companies have direct financial relationships with pharmaceutical (GlaxoSmithKline, Pfizer) and biotechnology (Genentech) companies and universities (University of Chicago) to name a few[2]; and

Whereas, Privacy breaches have occurred, including the hacking of a genetic testing company, MyHeritage, which affected 92,000,000 individuals,[3] with the potential for other abuse by governments, companies, or criminals with direct or indirect access (e.g. hacking, sale by unauthorized persons, release by disgruntled employees); and

Whereas, In up to 12-18% of cases, the consumers using information on recreational genetic genealogy databases are at risk for re-identification in the event of a data breach if their genetic information were cross-referenced against other information, such as their date of birth and state of residence[4]; and

Whereas, The Health Information Portability and Accountability Act (HIPAA) allows the transfer of date of birth and state of residence information without penalty; and

Whereas, The Genetic Information Non-Discrimination Act (GINA, 2008)[5] prevents discrimination by health insurance companies and employers based on acquired genetic information, but these restrictions do not apply to life, disability, or long-term care insurance companies, possibly causing some insurance application rejections; and

Whereas, Only 17 states have additional laws restricting the use of genetic information in determining life and disability insurance coverage, and only eight states for long-term care insurance; and

Whereas, Genetic information and research continues to evolve, resulting in technology advancements whereby past user information may be used negatively against those individuals; therefore be it

RESOLVED, That our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-315.983, "Patient Privacy and Confidentiality," by addition to align with current research and privacy infringement findings, as follows:

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, while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.

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. Wheher 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. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process.

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. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.

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.

a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To –Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;

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 (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference (Directive to Take Action); and be it further

RESOLVED, That our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-19)

Introduced by: Illinois

Subject: Repeal or Modification of the Sunshine Act

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The Physician Payments Sunshine Act was part of the 2010 Affordable Care Act as a way to document publicly the financial interactions between industry and physicians by requiring the medical industry, including Pharma, device manufacturers, and group purchasing organizations, to document any payments and gifts valued above $10; and

Whereas, The Sunshine Act data includes cash, in-kind items or services, stock, consulting fees, honoraria, gifts, entertainment, food, travel, research, charitable contributions, royalties or licenses, current or prospective ownership or investment interest, speaker compensation for CME, and grants; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) maintains the CMS Open Payments website, which has been up and running since 2014, with data collection having begun in 2013; and

Whereas, Advocates of the Sunshine Act sought to make the public aware of the relationship between industry and the medical community, such that physicians would become less willing to accept payments from industry in order to reduce the influence of industry on the practice of medicine; and

Whereas, Recent data from the CMS website shows the number of records published has remained at about 12 million since 2014; the total value, including research and investments, was $7.86 billion in 2014 and has increased to almost $8 billion in subsequent years; and the number of physicians with payment records was roughly 625,000 in 2014 and has continued to climb to 631,000 in 2016, the most recent year for which data has been published; showing that the number of physicians and the value of payment records has not had the anticipated effect of reduced industry-physician relationship and influence; and

Whereas, The Sunshine Act has created an undue burden on practicing physicians to maintain records and review the accuracy of the data submitted, and has not been shown to curtail the financial interactions between manufacturers and group purchasing organizations with physicians; therefore be it

RESOLVED, That our American Medical Association adopt as policy opposition to the Physician Payments Sunshine Act as it currently is written and implemented (New HOD Policy); and be it further

RESOLVED, That our AMA support either repeal of the current Sunshine Act or significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the burden and “hassle factor” and support efforts at administrative simplification for physicians, which the Center for Medicare and Medicaid Services and the organized medical community has supported, if any portion of the Act is maintained. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-19)

Introduced by: Illinois

Subject: Mandates by ACOs Regarding Specific EMR Use

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The private practice of medicine has protected the relationship between doctor and patient; and

Whereas, The patient chart and its data are protected under HIPAA; and

Whereas, The ownership of the chart rests with the doctor originating the chart; and

Whereas, The continued art and science of the practice of medicine depends on the protected relationship of the doctor and the patient, and the documentation of that relationship; and

Whereas, Electronic medical records have improved the documentation of the doctor-patient relationship; and

Whereas, The access to the patient chart is protected by HIPAA; and

Whereas, The private practice is affected by forces in the free marketplace; and

Whereas, The access and ownership of the patient chart has effect on its value in the marketplace; and

Whereas, The ownership of the chart has not been ruled on in most states; and

Whereas, The spread of Accountable Care Organizations (ACOs) may direct referrals within a geographic area and have restricted trade; and

Whereas, All electronic medical records are to move to interoperability as defined and mandated by the Centers for Medicare and Medicaid Services (CMS) for compliance with federal programs; and

Whereas, There are means of sharing data between organizations in accordance with HIPAA via alliances like CommonWell Health Alliance and Carequality Interoperability Framework that are in common usage for patient data and its interoperability; and

Whereas, The use of alliances such as CommonWell Health Alliance and Carequality Interoperability Framework have accelerated the ability of unrelated healthcare entities including inpatient and outpatient facilities to share data through interoperability; and

Whereas, ACOs have begun to mandate the use of single and specific EMR software vendors; therefore be it

RESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR) (New HOD Policy); and be it further

RESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-19)

Introduced by: New York

Subject: Air Ambulances

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Across the country, less populated areas are being served by both not-for-profit and for-profit air medevac services; and

Whereas, Most communities in the US are serviced by land-based non-profit providers such as police or fire departments; and

Whereas, In urban communities, hospitals frequently offer air ambulance services while rural communities must rely heavily on privately owned medevac ambulance service companies; and

Whereas, For-profit companies compete with land-based, non-profit services by cleverly monitoring police and fire department emergency radio bands; and

Whereas, States face poor regulation of air ambulance business overseen by the FAA; and

Whereas, There is a concern about the excessive costs of the private medevac sector; and

Whereas, Research states that 60% of patients transported by air would not have suffered a lower standard of medical care if they had been transported by land; and

Whereas, Land-based services are less expensive and less dangerous; and

Whereas, Exorbitant, poorly regulated fees can leave a patient with an out-of-pocket bill of upwards of $40,000-$60,000 after insurance payments which has caused some patients to file bankruptcy; and

Whereas, Several states have introduced legislation to limit the predatory behaviors of private medevac companies but some states believe that legislation should be addressed at the federal level; therefore be it

RESOLVED, That our American Medical Association support federal legislation which would:

1. Establish an <u>expedited</u> independent dispute resolution system to resolve payment disputes between emergency air ambulance providers and health insurers; and

2. Ensure that such independent dispute resolution process would ensure the patient be "held harmless" except for applicable insurance policy in-network cost-sharing requirements. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-19)

Introduced by: New York

Subject: Use of FAIR Health

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, For FAIR Health to serve its purpose, it must continue to report Usual and Customary Rate (UCR) data as it has been doing; and

Whereas, Tremendous effort was expended to create FAIR Health as an independent database, that would accurately report the charge data and not be influenced to alter the collected data; and

Whereas, FAIR Health's database contains 28 billion claims collected from all 50 states; and

Whereas, FAIR Health's database is used a reference point for charge data by numerous states; and

Whereas, There is increasing usage by states of so-called "all payer databases" (APDs) that contain payment data supplied by health insurance companies; and

Whereas, Such APDs often contain incomplete data, such as excluding data from self-insured health plan sources; and

Whereas, Congress is currently debating whether to enact legislation that would set forth payment standards and/or processes to determine payments for out of network surprise hospital medical bills; and

Whereas, Some legislators have indicated a preference for use of APD payment data for an out of network payment benchmark instead of use of comprehensive charge data supplied by physicians; and

Whereas, Failure to fairly account for charge data in an out of network surprise bill benchmark could have disastrous consequences for physicians attempting to negotiate fair contracts with health insurance companies; therefore be it

RESOLVED, That our American Medical Association advocate that any legislation addressing surprise out of network medical bills use FAIR Health usual and customary data and not all payer database data. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-19)

Introduced by: New York

Subject: Pharmacy Benefit Managers

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Pharmacy Benefit Managers (PBMs) choose medications based on the cost; and

Whereas, Patients have different responses to medications and need a variety of medications available to them; and

Whereas, There have been instances where health insurers and PBMs refuse to continue to continue covering needed pain management medications for severely ill patients when such patients are transitioned from a hospital to a community based care setting such as hospice; and

Whereas, Failure to sufficiently address patients' pain control needs is one factor that leads to patients seeking medical assistance to end their life prematurely; therefore be it

RESOLVED, That our American Medical Association advocate through all appropriate means to ensure that medications used to stabilize palliative and hospice patients for pain and delirium in the hospital continue to be covered by pharmacy benefit plans after patients are transitioned out of the hospital. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-19)

Introduced by: New York

Subject: Financial Penalties and Clinical Decision-Making

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Physicians along with other stakeholders share the goal of providing cost effective care; and

Whereas, Other stakeholders (such as payers – who as a group have access to enormous amounts of utilization data) can be helpful in identifying cost centers and even in the development of targets to work toward in order to achieve the shared goal of providing cost effective care; and

Whereas, It is physicians who have a perspective unique among the stakeholders to assess the clinical course and outcomes (the other variables in calculating cost effectiveness) – particularly when outcomes data is insufficient to draw objective conclusions; and

Whereas, Recently a New York insurer (one with significant market share) observed that despite increasing reimbursement for a less expensive injectable drug (although one unapproved for this indication), physicians did not change their utilization patterns in favor of this drug in the manner sought by that insurer; and

Whereas, This insurer is now being investigated by the New York Department of Financial Services for this practice; and

Whereas, In response, rather than assess all the factors (rather than just the economic ones) that contribute to physician preferences in their choice of therapy (such as indication, effectiveness, therapeutic failure/responses, dosing, safety), the company elected to instead impose financial penalties on practices that have a member that is a statistical outlier when compared to the aggregate of physicians within the plan; and

Whereas, Those penalties apply not only to the individual outlier physician but to all the services rendered by all of the members of the practice – the penalties extend even to those physicians whose utilization is within the target (and, presumably, to those who do not even use these drugs); therefore be it

RESOLVED, That our American Medical Association oppose the practice of a payer utilizing statistical targets alone (and not outcomes data) to determine ‘cost effectiveness’ of a therapeutic choice (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the practice of a payer imposing financial penalties upon physicians and/or associated physicians based upon the use of statistical targets without first considering the clinical factors unique to each patient’s claim. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-19)

Introduced by: New York

Subject: The Term Physician

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Allied health professionals are continually trying to extend their scope of service; and

Whereas, There needs to be transparency for patients to know who is treating them and to be able to evaluate the credentials of that provider of care; and

Whereas, There are doctorate degrees being granted to many allied health professionals and the term doctor in the clinical setting may be misinterpreted by patients; therefore be it

RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that the term physician be limited to those people trained in accordance with Accreditation Council for Graduate Medical Education guidelines and have an MD, DO or a recognized equivalent physician degree and that the term not be used by any other organization or person involved in healthcare. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-19)

Introduced by: New York

Subject: Reimbursement for Health Information Technology

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The delivery of healthcare is being transformed through the use of technology; and

Whereas, Physician practices need to keep up with new technology; and

Whereas, Technology has resulted in an increase in costs to physician practices that did not exist 10 years ago and these costs include transactional costs for each E prescription that is sent, monthly fees for the electronic medical record, the purchase of hardware, financing and staff support needed to maintain this technology; and

Whereas, Reimbursement for physicians has not kept pace with these increased expenses; and

Whereas, Physician practices need to innovate; and

Whereas, E/M codes were never designed to support these expenses or innovation; therefore be it

RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that third party payers allow physician practices to charge a technology fee equal to the copayment of the patient's plan. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-19)

Introduced by: New York

Subject: Eliminate the Word “Provider” from Healthcare Contracts

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Many healthcare contracts from insurers and government agencies use the word “provider” to mean “physicians” and all other “healthcare professionals”; and

Whereas, The word “provider” is dictionary defined as one of the following: “wage earner”, “income producer”, “job holder”, “laborer”, “meal ticket”, and “one who brings home the bacon”; and

Whereas, It is demeaning to call a highly-educated physicians and healthcare professionals “providers”; therefore be it

RESOLVED, That our American Medical Association seek legislation to ensure that all references to physicians in government and insurance contracts, agreements, published descriptions, and printed articles eliminate the word “provider” and substitute the accurate and proper term “physician”. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-19)

Introduced by: New York

Subject: Medicare Vaccine Billing

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas AMA Policy D-440.981, "Appropriate Reimbursements and Carve-outs for Vaccines," states:

> Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and

Whereas, Medicare continues to not reimburse physicians for the cost of some immunizations; and

Whereas, Medicare will reimburse pharmacies for those immunizations, creating an incentive to go to a pharmacy for all vaccinations; therefore be it

RESOLVED, That our American Medical Association advocate that a physician's office can bill Medicare for all vaccines and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices.
Citation: (BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-19)

Introduced by: New York

Subject: Payment for Medications Used Off Label for Treatment of Pain

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, There is an epidemic of opioid abuse in America; and

Whereas, The efforts to combat that epidemic is to restrict the use of opioids; and

Whereas, Insurance companies and government programs restrict the off-label use of medications to Federal Drug Administration (FDA) approved indications and many current pain medications were not approved by the FDA for pain management or have a very narrow indication for pain treatment; and

Whereas, Many pharmacy benefit plans will not cover these medications, leaving a treatment gap for patients with pain; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-19)

Introduced by: Oklahoma

Subject: Medical Marijuana License Safety

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Our American Medical Association supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; and

Whereas, Our AMA encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care within the safeguards applicable to protected health information; and

Whereas, Our AMA encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; and

Whereas, Our AMA encourages states to share access to PDMP data across state lines; and

Whereas, By 2018, 33 states, the District of Columbia, Guam, and Puerto Rico, have passed legislation to legalize medical marijuana, including Oklahoma; and

Whereas, In 2018, Oklahoma State Question 788, Medical Marijuana Legalization Initiative, became law of the land and lacks adequate patient safeguards in multiple areas; and

Whereas, Patient safety standards have not been implemented in all state legislation that have legalized medical marijuana; and

Whereas, Physicians need accurate and reliable information to give high-level care to their patients; therefore be it

RESOLVED, That our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

RELEVANT AMA POLICY

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939
Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.
Citation: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-19)

Introduced by: Pennsylvania

Subject: Study of Confidentially and Privacy Protection in the Treatment of Substance Disorders

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Privacy rules are established in the "Health Information Protection and Accountability Act" (HIPAA, 1996). These rules protect personal health information, setting conditions on disclosures and allowing patient information to be shared to coordinate care without obtaining additional consents; and

Whereas, Confidentiality regulations were established in 1972 in the "Confidentiality of Alcohol and Drug Abuse Patient Records Act" (42 CFR Part 2). These regulations are applied to the disclosure and re-disclosure of patient information. Part 2, (not HIPAA), prohibits sharing of information that could identify a patient seeking treatment for a substance related disorder; and

Whereas, Because of Part 2, treatment records for substance related disorders are separated from a patient's medical record, acting as a life-threatening barrier preventing medical providers from having access to their patients' full medical histories, limiting integration, hindering coordination and resulting in less robust, whole person, safe, and optimally effective care; and

Whereas, The opioid epidemic (among other substance related disorders) which has resulted in excess mortality in every community across the country, and costs in the billions of dollars annually, may indicate that these protections have failed to reduce reluctance to enter treatment; and

Whereas, It is not clear nearly 50 years later, that Part 2 confidentiality is a concern preventing individuals from seeking treatment for their addictions, or that patients considering treatment, care more about confidentiality than coordination of care; therefore be it

RESOLVED, That our American Medical Association study whether the confidentiality protections of 42 CFR Part 2 outweigh the potential benefits of coordinating care with HIPAA privacy protections in the treatment of substance related disorders. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-19)

Introduced by:	American College of Obstetricians and Gynecologists, American Psychiatric Association, New Jersey, Illinois American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry
Subject:	Extending Medicaid Coverage to 12-Months Postpartum
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

Whereas, Medicaid is the largest single payer of maternity care in the United States, covering 42.6 percent of births and playing a critical role in ensuring healthy moms and babies[i]; and

Whereas, Medicaid is a women's health success story and is the pathway to jobs and financial stability for women and girls. Girls enrolled in Medicaid as children are more likely to attend college, and Medicaid coverage during pregnancy and a newborn's first year of life increases the likelihood that the child will experience upward mobility[ii iii]; and

Whereas, Medicaid pregnancy coverage lapses at the end of the month after 60-days postpartum; and

Whereas, The postpartum period is simultaneously a time of vulnerability and maternal health risk, and a transition period with often unmet maternal health needs[iv,v]; and

Whereas, The American College of Obstetricians and Gynecologists emphasize the importance of the "fourth trimester" and optimizing postpartum care to improve maternal health outcomes and support ongoing health and well-being[vi]; and

Whereas, The United States is the only industrialized nation with a rising maternal mortality rate[vii]; and

Whereas, A report from nine maternal mortality review committees estimated that more than 60 percent of maternal deaths are preventable[viii]; and

Whereas, Findings from state maternal mortality review committees reveal a growing number of maternal deaths linked to cardiovascular disease, cardiomyopathy, and overdose and suicide, with many of these deaths occurring during the postpartum period[ix]; and

Whereas, Missouri was the first state to pass legislation extending Medicaid coverage to 12-months postpartum for women in active treatment for a substance use disorder[x]; and

Whereas, The Texas Maternal Mortality and Morbidity Task Force recommended extending Medicaid coverage to 12-months postpartum to ensure that "medical and behavioral health conditions can be managed and treated before becoming progressively severe.[xi]; and

Whereas, Legislation in several states, including Texas, Illinois, California, and New Jersey, has been introduced in 2019 to extend Medicaid coverage to 12-months postpartum; and

Whereas, Federal legislation has been introduced in 2019 to extend Medicaid coverage to 12-months postpartum; therefore be it

RESOLVED That our American Medical Association support and actively work toward enactment of state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

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[i] Martin JA, Hamilton BE, Osterman MJK, Driscoll AK, and Drake P. Births: Final Data for 2016. National vital statistics reports; vol 67 no 1. Hyattsville, MD: National Center for Health Statistics. 2018. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf.

[ii] National Women's Law Center. Medicaid at 50: Celebrating Medicaid's Contributions to Women's Economic Security (July 2015). Retrieved from https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/final_nwlc_medicaid50th_whitepaper_3.pdf.

[iii] Brown, DW, Kowalski, AE, and Lurie, IZ (2015). Medicaid As an Investment in Children: What Is the Long-Term Impact on Tax Receipts?, National Bureau of Economic Research Working Paper, 20835. Retrieved from http://www.nber.org/papers/w20835.

[iv] Spelke B and Werner E. The Fourth Trimester of Pregnancy: Committing to Maternal Health and Well-Being Postpartum. R I Med J (2013). 2018 Oct 1;101(8):30-33.

[v] Tully KP, Stuebe AM, and Verbiest SB. The fourth trimester: a critical transition period with unmet maternal health needs. Am J Obstet Gynecol. 2017 Jul;217(1):37-41.

[vi] Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50.

[vii] MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstet Gynecol. 2016;128(3):447-55.

[viii] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Retrieved from http://reviewtoaction.org/Report_from_Nine_MMRCs.

[ix] Ibid.

[x] Vestal, Christine. "For Addicted Women, the Year After Childbirth Is the Deadliest." Pew Stateline. 14 Aug 2018. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/14/for-addicted-women-the-year-after-childbirth-is-the-deadliest.

[xi] Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, September 2018. Retrieved from https://www.dshs.texas.gov/mch/pdf/MMMTFJointReport2018.pdf.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-19)

Introduced by: Kentucky, Mississippi, Oklahoma, West Virginia

Subject: Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, In 2016, the American Medical Association House of Delegates adopted Resolution 208 relating to patients being potentially endangered by ubiquitous television commercials that seek plaintiffs regarding medications; and

Whereas, Since that time the issue has become even more pervasive, and new research in addition to direct physician experiences has indicated that actual patient harm is occurring; and

Whereas, Many of these advertisements utilize misleading techniques, including the use of terms like “Medical Alert” to imply the advertisement is some kind of public service advertisement, the use of the term “recall” even when a drug or other device remains approved by the US Food and Drug Administration, or the use of governmental logos to imply that the advertisement is associated with a governmental agency; and

Whereas, Few of the advertisements fairly identify the sponsor and purpose of the advertisement in any meaningful or understandable manner, leading individuals to potentially provide their private and protected health information to third parties under misleading circumstances; and

Whereas, While there is clearly a potential for danger when stopping or altering a course of care agreed upon with a physician or seeking to modify or remove a medical device without first consulting a physician about that change, few of the advertisements provide this very important safety information in any meaningful way; and

Whereas, The state of Tennessee has recently adopted new rules creating common-sense regulations to protect patient health and fairly address these other concerns; therefore be it

RESOLVED, That our American Medical Association encourage state legislatures to consider and adopt legislation that helps protect patient health by creating fair rules and regulations around attorney advertisements that:

1. Prohibit misuse of governmental logos or the term “recall”
2. Provide clear warning of the dangers in stopping a course of treatment without consulting with a physician and
3. Require written consent before sharing personal health information. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/01/19

RELEVANT AMA POLICY

Attorney Ads on Drug Side Effects H-105.985
Our AMA will advocate for a requirement that attorney advertising which may cause patients to discontinue medically necessary medications have appropriate and conspicuous warnings that patients should not discontinue medications without seeking the advice of their physician.
Citation: Res. 208, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-19)

Introduced by: Wisconsin

Subject: Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Addiction involving tobacco use remains our nation's leading cause of preventable death; and

Whereas, Adult cigarette smoking rates have dropped to about 14%, certain populations e.g., the poor, and persons with behavioral health conditions, continue to smoke at much higher rates, and still about 20% of adult deaths each year are attributable to tobacco use; and

Whereas, Passive exposure to tobacco smoke contributes about 10% of the tobacco-related mortality in our nation so that even non-smokers experience potentially lethal health impacts from the tobacco smoking of others; and

Whereas, Aligned with the first step in quality improvement is measurement (to know the current state before interventions that might improve it are implemented), the first step in disease control is surveillance--knowing baseline levels of disease incidence and prevalence so that the results of interventions to reduce disease onset, duration and impact can be accurately measured against a reference point; and

Whereas, Case definitions, and the words used to make up those definitions, are of critical importance in epidemiology and in clinical medicine, so that there is concurrence and consistency in the description and enumeration of clinical states, and so that public health surveillance efforts are accurate; and

Whereas, Health records in North America have shifted predominantly to electronic health records (EHRs), in which words used by clinicians are transformed into computer language and stored as digital information that comprise chart documents; and

Whereas, The Office of National Coordinator of Health Information Technology (ONC) is a component of the federal Department of Health and Human Services (DHHS) and is charged by Congress, among other things, with recommending uniform standards for computer language in EHRs to interface with the human language of physicians and other members of health care clinical teams; and

Whereas, SNOMED is the systematized standard nomenclature format for terms used in EHR software designed and sold by health information technology (HIT) vendors, and provides a standardized, consistent language by which computer software designers fit human words into categories of digitally recognized terms to describe symptoms, illnesses, medical and surgical procedures, and even outcome measures in healthcare today; and

Whereas, Proclamations and directives from the ONC are influential in guiding HIT vendors in their design of EHR software in a standardized way across commercial EHR platforms, allowing for interoperability of software systems, standardized collation of health information into databases and information exchange platforms, and activities of health care practitioners and public health officials alike to improve health care processes to generate better outcomes for patients and populations of patients; and

Whereas, Current terminology in SNOMED[1] regarding a patient's smoking status are overlapping and therefore imprecise and confusing, and lead to problems with data analysis and, arguably more significantly, problematic data entry by clinicians as they are not sure which categorization of smoking status to enter into a patient's electronic health record; and

Whereas, SNOMED terminology[1] regarding smoking status and passive smoking exposure can be simplified by elimination of the vague, undefined, and overlapping terms "heavy tobacco smoker" and "light tobacco smoker" and consolidating the terms "smoker, current status unknown" and "unknown if ever smoked" into the single item "smoking status unknown" (Appendix A), making it more likely that clinicians will enter such data into EHRs at both higher rates and with more precision, to inform their care and inform epidemiologists about trends in improvement or worsening in our nation's population health statistics regarding tobacco-related health conditions and their impacts[2]; and

Whereas, These simplifications have been developed by the Center for Tobacco Research and Intervention (CTRI) at the University of Wisconsin School of Medicine and Public Health (UWSMPH), and endorsed by the Association for the Treatment of Tobacco Use and Dependence[2]; therefore be it

RESOLVED, That our American Medical Association support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record so that the categories are discrete, non-overlapping, and better understood per The Association for the Treatment of Tobacco Use and Dependence 2019 recommendations as follows:

Smoking status categories: Current Every Day Smoker, Current Some Day Smoker Former Smoker, Never Smoker, and Smoking Status Unknown

Passive smoking exposure: Exposure to Second Hand Tobacco Smoke, Past Exposure to Second Hand Tobacco Smoke, No Known Exposure to Second Hand Tobacco Smoke (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
[1] The Office of the National Coordinator for Health Information Technology (ONC). Representing patient tobacco use (smoking status). Available at: https://www.healthit.gov/isa/representing-patient-tobacco-use-smoking-status Accessed April 24, 2019.
[2] Association for the Treatment of Tobacco Use and Dependence. Provider Information. The Association for the Treatment of Tobacco Use and Dependence (ATTUD) Recommendation for Recording Smoking Status and Passive Smoke Exposure in the Electronic Health Record Available at: https://www.attud.org/pdf/ATTUD%20Recommendations%20for%20Recording%20Smoking%20Staus%20in%20EHR.pdf Accessed April 24, 2019.

RELEVANT AMA POLICY

Tobacco Control Content in Electronic Health Records H-478.990
Our AMA encourages: (1) physicians to capture information from all their patients on tobacco use, secondhand smoke exposure, cessation interest, and past quit attempts; and (2) the development of EHR systems that provide physicians with the ability to capture information on specific health behaviors deemed appropriate by the physician and that provide physicians the option to utilize automated reminders to benefit their patients.
Citation: (BOT Rep. 15, A-09

Appendix A:

Smoking Status Documentation in the Electronic Health Record Background and Context:
The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have played a major role in encouraging the adoption and utilization of EHRs in the United States. In part, because of CMS's Meaningful Use of EHRs Program, outpatient and inpatient clinical settings today almost universally screen and document patients for smoking and document patient "Smoking Status" in the EHR. "Smoking Status" is a required component for ONC's CEHRT/Health IT Certification Program EHR software certification.

However, confusion remains for many clinicians and health care systems about the *categories to document smoking status*. The current SNOMED CT options overlap. As a result, they often create confusion at the point of care.

History of "Smoking Status" Classification/Documentation in the EHR
CMS Meaningful Use (MU) recommends the following criteria for smoking status using a classification based on the National Health Interview Survey (NHIS):
• Current every day smoker
• Current some day smoker
• Former smoker
• Never smoker
• Smoker, current status unknown
• Unknown if ever smoked
• Heavy tobacco smoker
• Light tobacco smoker

2015 Health Information Technology Certification Criteria Final Rule removed the requirement that reporting entities must use the 8 SNOMED CT codes to document smoking status. Specifically, the 2015 Health Information Technology Certification Criteria Final Rule described reporting on "Smoking Status" in the following way:

> "*We have adopted a "smoking status" certification criterion that does not reference a standard*."….."*In consideration of the concerns expressed by commenters regarding development burden and the proper mapping of all available smoking status codes within SNOMED CT to the specified 8 SNOMED CT1 for exchange, we believe that the best path forward is* ***the adoption of a "smoking status" criterion that would simply require a Health IT Module to demonstrate that it can enable a user to record, change, and access a patient's smoking status.*****"**

Looking Forward
In an effort to further ***clarify and simplify "Smoking Status" documentation***, we encourage ONC to advise health information technology developers, health care systems, hospitals and health care providers to use non-overlapping criteria to document smoking status. An example of such non-overlapping criteria/classifications are shown below for smoking status and passive smoke exposure:

Smoking Status	**SNOMED CT Code**
Current Every Day Smoker	449868002
Current Some Day Smoker	428041000124106

Former Smoker	8517006
Never Smoker	266919005
Smoking Status Unknown	266927001

Passive Smoking Exposure	SNOMED CT Code
Exposure to Second Hand Tobacco Smoke	16090371000119103
Past Exposure to Second Hand Tobacco Smoke	99009004
No Known Exposure to Second Hand Tobacco Smoke	711563001

Tobacco Control Content in Electronic Health Records H-478.990
Our AMA encourages: (1) physicians to capture information from all their patients on tobacco use, secondhand smoke exposure, cessation interest, and past quit attempts; and (2) the development of EHR systems that provide physicians with the ability to capture information on specific health behaviors deemed appropriate by the physician and that provide physicians the option to utilize automated reminders to benefit their patients. (Policy Timeline: BOT Rep. 15, A-09)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-19)

Introduced by: Resident and Fellow Section

Subject: Extending Pregnancy Medicaid to One Year Postpartum

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Medicaid covers postpartum care for women with pregnancy Medicaid for only sixty days after giving birth; and

Whereas, Thirteen states did not adopt the Affordable Care Act's Medicaid expansion plan and thus pregnant women living in these states cannot obtain health care coverage through Medicaid after pregnancy; and

Whereas, Women with pregnancy induced hypertension, gestational diabetes, post-partum depression and/or other comorbidities require further follow-up with a primary care physician, however are unable to continue their medical care due to the current sixty-day policy; and

Whereas, Approximately one in five pregnant women have one or more chronic medical conditions that may complicate pregnancy and increase the risk of pregnancy-related death, which is defined as the death of a woman during pregnancy or within one year of giving birth; and

Whereas, The United States has the worst maternal mortality rate amongst developed countries; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to extend pregnancy Medicaid to a minimum of one year postpartum. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:

1. ACOG Committee Opinion (2018). "ACOG Committee Opinion No. 736: Optimizing postpartum care". Obstetrics and Gynecology 131(5): e140-e150.
2. Kaiser Family Foundation (2017). "Medicaid coverage of pregnancy and perinatal benefits: Results from a state survey". Retrieved Oct 23 from https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/.
3. Kaiser Family Foundation (2018). "Status of state action on the Medicaid expansion decision". Retrieved Oct 23 from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#notes.
4. Bouscaren, D (2017). "Researchers make case for extending Medicaid coverage to low-income mothers". Retrieved Oct 23 from http://news.stlpublicradio.org/post/researchers-make-case-extending-medicaid-coverage-low-income-mothers#stream/0.
5. CDC (2018). "Pregnancy mortality surveillance system". Retrieved Oct 23 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm.
6. Medicaid and CHIP Payment and Access Commission (2014). "Chapter 3: Issues in pregnancy coverage under Medicaid and exchange plans". Retrieved Oct 23 from https://www.macpac.gov/wp-content/uploads/2015/01/Issues_in_pregnancy_Coverage_under_Medicaid_and_Exchange_Plans.pdf

RELEVANT AMA 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.
Citation: CSAPH Rep. 3, A-09; Appended: Res. 403, A-11; Appended: Res. 417, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-19)

Introduced by: Resident and Fellow Section

Subject: DACA in GME

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, There is an anticipated shortage of over 100,000 doctors by the year 2030, especially in primary care; and

Whereas, A recent study in the Journal of Graduate Medical education found that "there are simply not enough US-trained physicians to fill all the available residency and fellowship positions" in primary care specialties[6]; and

Whereas, A 2018 study by the American Medical Association on non-US IMGs found that 64% are working in primary care, and 66% of non-US IMGs that matched in 2018 did so in primary care fields; and

Whereas, In 2014-2015, there were 1,879 physicians from Muslim-majority countries including many on the travel ban list, practicing on a J-1 visa, a visa obtained during residency training that upon completion of training, requires holders to find "J-1 waiver" jobs which recruit physicians into underserved areas[3];" and

Whereas, A New York Times article described "changes in visa policies prevent foreign graduate (IMG) doctors from practicing and increase medical provider shortages especially in rural communities[2];" and

Whereas, 2018 saw the lowest number of non-US IMG applicants since 2005[16]; and

Whereas, An open-letter by ACGME described the "profound moral distress [a travel ban] has provoked within the health care community[1];" and

Whereas, ECFMG Statement to Supreme Court (2018) "In the United States, where one-quarter of our physicians have received their medical degree outside the United States and Canada, the ability to provide accessible, high-quality health care depends on our ability to continue to attract highly qualified physicians from around the world. Anything that disrupts the flow of these talented and qualified professionals into the United States will have a negative and potentially long-term impact on patient care. We urge immigration policymakers to consider the many contributions that foreign national physicians make to our healthcare system and our economy, and to ensure that United States remains an attractive option for the best and brightest minds from around the world" [4]; and

Whereas, New data shows that in 2017, U.S. Citizenship and Immigration Services denied more H-1B petitions, preventing more foreign nationals from working in America,[12] and there is concern that these rejections will affect medical residents in training in the U.S[13]; and

Whereas, Multiple US medical organizations including the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges, Alliance for Academic Internal Medicine, American Academy of Family Medicine, American Academy of Pediatrics, and the American College of Physicians have expressed concern over executive orders limiting immigration and their impact on graduate medical education[1, 6-11]; therefore be it

RESOLVED, That American Medical Association Policy D-255.991, "Visa Complications for IMGs in GME," be reaffirmed (Reaffirm HOD Policy); and be it further

RESOLVED, That AMA Policy D-350.986, "Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages," be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1 Accreditation Council for Graduate Medical Education. Nasca immigration letter. February 2, 2017. https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Nasca-Letter-Immigration-2-2-17.pdf. Accessed August 19/2018.
2 Rural Areas Brace for a Shortage of Doctors Due to Visa Policy. March 18,2017. https://www.nytimes.com/2017/03/18/us/doctor-shortage-visa-policy.html
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RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
Citation: BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17

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.
Citation: Res. 305, A-15; Appended: Late Res. 1001, I-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency

Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18

Impact of Immigration Barriers on the Nation's Health D-255.980
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
Citation: Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
Citation: (Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-19)

Introduced by: New York

Subject: Physician Access to their Medical and Billing Records

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Contracts include language that medical and billing records are proprietary and the property of the employer and may limit access to the treating physician during employment or after separation; and

Whereas, Billing is frequently signed by physicians or billed under the physician's identifier; and

Whereas, Physician review is crucial to any compliance program; therefore be it

RESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it further

RESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-19)

Introduced by: Alabama

Subject: Controlled Substance Management

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Physicians continue to play a key role in combatting the US opioid crisis; and

Whereas, Physicians who prescribe controlled substances must be vigilant regarding potential diversion or other misuse of the medications they prescribe; and

Whereas, Many states require physicians to access their state's prescription monitoring program data for patients receiving controlled substance prescriptions from them; and

Whereas, Pill counts can also be an effective part of a patient's opioid management plan; and

Whereas, Many state medical licensing boards strongly encourage physicians to conduct pill counts to combat diversion of controlled substances; and

Whereas, Accessing patient data in a prescription monitoring program database and pill counts, whether performed by the physician or delegated to someone else in their practice, carry with them a labor cost borne by the physician; and

Whereas, There is currently no mechanism for physicians to be fairly compensated for this additional work effort; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) and interested physician groups to strongly advocate for a mechanism by which physicians may be compensated for controlled substance management (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly encourage CMS and private payers to recognize and establish equitable payment for controlled substance management. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-19)

Introduced by: American Society of Anesthesiologists

Subject: Truth in Advertising

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Our American Medical Association (AMA) supports nonphysician providers' role within the patient-centered, physician-led health care team; and

Whereas, Nonphysician providers' contributions to the delivery of care should not be confused with being a medical specialist; and

Whereas, Physicians receive 12 to 14 years of education, including medical school, and 12,000 to 16,000 hours of clinical training to specialize in the practice of medicine with the necessary knowledge to understand and treat the entire human body; and

Whereas, In 2018 the American Association of Nurse Anesthetists (AANA) approved the descriptor "nurse anesthesiologist" as an appropriate term to refer to a nurse anesthetist; and

Whereas, In 2018 the New Hampshire Board of Nursing issued a position statement that recognizes "Nurse Anesthesiologist" and "Certified Registered Nurse Anesthesiologist" as optional, accurate descriptors"[1]; and

Whereas, Having strong truth-in-advertising laws helped safeguard patients in Texas, where the Texas Association of Nurse Anesthetists shared its awareness of the AANA approval of the "nurse anesthesiologist" term and cautioned its members that any nomenclature comparing nurses to physicians that misleads patients could result in disciplinary or legal action; and

Whereas, Our AMA policy provides that anesthesiology is the practice of medicine; and

Whereas, To avoid unnecessary confusion by other health care providers, the public and especially patients and their families, efforts must be taken to prevent the misappropriation of medical specialties titles; therefore be it

RESOLVED, That our American Medical Association reaffirm support of the Scope of Practice Partnership's Truth in Advertising Campaign to ensure patients receive accurate information about who is providing their care (AMA Policy H-405.969) (Reaffirm HOD Policy); and be it further

[1] Available at https://www.oplc.nh.gov/nursing/documents/nh-bon-nurse-anesthesiologist.pdf

RESOLVED, That our AMA oppose any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses and national board certification. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Anesthesiology is the Practice of Medicine H-160.929
It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry.
Citation: (Sub. Res. 216, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 9, I-11

Definition of a Physician H-405.969
1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.
Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu or Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Clarification of CDC Opioid Prescribing Guidelines

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The Centers for Disease Control and Prevention (CDC) published their *Guideline for Prescribing Opioids for Chronic Pain* in 2016 to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings; and

Whereas, The CDC explicitly stated in this guideline that it was developed for primary care clinicians who prescribe opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care; and

Whereas, By February of 2019, over half of all states had enacted laws in response to these guidelines that restrict the prescribing or dispensing of opioids for acute pain, codifying 7-day prescription fill limits into statute[1]; and

Whereas, New Hampshire, Ohio, Oregon, Rhode Island, Utah, Vermont, Virginia, Washington and Wisconsin have all passed legislation authorizing state regulatory entities to set their own enforceable opioid prescribing limits or guidelines[2]; and

Whereas, A 2018 study performed by the American Cancer Society Cancer Action Network (ACS CAN) together with the Patient Quality of Life Coalition (PQLC) showed that nearly half of cancer patients (48 percent) and more than half of those with other serious illnesses (56 percent) surveyed said their doctor indicated treatment options for their pain were limited by laws, guidelines or insurance coverage;[3] and

Whereas, The CDC issued a letter to the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO), and the American Society of Hematology (ASH) on February 28, 2019 clarifying that clinical practice guidelines specific to cancer treatment, palliative care, and end of life care should be used to guide treatment and reimbursement decisions regarding the use of opioids as part of pain control in these circumstances[4]; and

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[1] National Conference of State Legislators. Prescribing Policies: States Confront Opioid Overdose Epidemic. NCSL website. http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx . Published October 31, 2018. Accessed April 19, 2019.
[2] Ibid.
[3] American Cancer Society Cancer Action Network. New Data: Some Measures Meant to Address Opioid Abuse Are Having Adverse Impact on Access to Legitimate Pain Care For Patients. ACS CAN Press Release. https://www.fightcancer.org/releases/new-data-some-measures-meant-address-opioid-abuse-are-having-adverse-impact-access. Published July 14, 2018. Accessed April 22, 2018.
[4] U.S. Department of Health and Human Services. CDC Opioid Guideline Clarification Letter. https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2019-CDC-Opioid-Guideline-Clarification-Letter-to-ASCO-ASH-NCCN.pdf. Published February 28, 2019.

Whereas, ASCO and NCCN have each published clinical practice guidelines addressing pain control for cancer survivors subsequent to the release of the CDC's Guideline for Prescribing Opioids for Chronic Pain; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy D-120.932, "Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids"; (Reaffirm HOD Policy) and be it further

RESOLVED, That our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC's Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Inappropriate Use of CDC Guidelines for Prescribing Opioids D-120.932
1. Our AMA applauds the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths.
2. Our AMA will actively continue to communicate and engage with the nation's largest pharmacy chains, pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy in opposition to communications being sent to physicians that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care. A report is due back to the House of Delegates at the 2019 Annual Meeting.
3. Our AMA affirms that some patients with acute or chronic pain can benefit from taking opioid pain medications at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate.
4. Our AMA will advocate against misapplication of the CDC Guideline for Prescribing Opioids by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia.
5. Our AMA will advocate that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level above the MME thresholds found in the CDC Guideline for Prescribing Opioids.
Citation: Res. 235, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-19)

Introduced by:	American College of Cardiology, American Society of Echocardiography, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions
Subject:	State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes
Referred to:	Reference Committee B (Charles Rothberg, MD, Chair)

Whereas, No scientific evidence exists that indicates mandatory echocardiogram or ECG screening will save student athletes; and

Whereas, Operationalizing government oversight of mass screening is prohibitively expensive; and

Whereas, The risk of "false positives" in mass screening environments is high and can lead to unwarranted anxiety in normal athletes, unnecessary additional testing, and inappropriate treatments and/or exclusion from sports; and

Whereas, The American Heart Association and the American College of Cardiology issued the definitive Scientific Statement on mandatory EKG and echocardiogram screening of student athletes on Sept. 15, 2014, and reaffirmed on Dec.1, 2015 in a Scientific Statement on Eligibility and Disqualification Recommendations for Competitive Athletes, which stated, “Mandatory and universal mass screening with 12-lead ECGs in large general populations of young healthy people 12 to 25 years of age to identify genetic/congenital and other cardiovascular abnormalities is NOT recommended for athletes and non-athletes alike (Class III, no evidence of benefit; Level of Evidence C);”[1] and

Whereas, The lowest high school death rates ever reported come from Minnesota, which mandates a comprehensive history and physical exam but not an echocardiogram or an ECG. The Minnesota evidence demonstrates that ensuring every athlete provides an accurate history and receives a quality exam is key to identifying those at greatest risk and avoiding unnecessary worry and testing of healthy students; and

Whereas, A unique natural experiment that included both ECG and echocardiogram screening identified diseases associated with sudden cardiac death in 0.38% of a large population during a 20-year period, yet most of the small number of cardiac deaths were due to cardiomyopathies not detected on screening;[2] therefore be it

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[1] Baron, BJ, et al. Eligibility and Disqualification Recommendations for Competitive Athletes With Cardiovascular Abnormalities: Task Force 2: Preparticipation Screening for Cardiovascular Disease in Competitive Athletes A Scientific Statement From the American Heart Association and American College of Cardiology. *Circulation* 2015;132: e267–e272.
[2] Malhotra, MB, et al. Outcomes of Cardiac Screening in Adolescent Soccer Players. *N Engl J Med* 2018; 379:524-534.

RESOLVED, That our American Medical Association and state and specialty medical societies oppose legislation mandating echocardiograms or ECGs as a condition of participation in scholastic sports. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-19)

Introduced by: American Psychiatric Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Clinical Neurophysiology Society, American College of Physicians, Colorado, Vermont, Washington, Wisconsin

Subject: Alignment of Federal Privacy Law and Regulations Governing Substance Use Disorder Treatment (42 CFR Part 2) with the Health Insurance Portability and Accountability Act

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, In 2017, an estimated 16.7 million people aged 12 or older received substance use disorder (SUD) treatment[1]; and

Whereas, Substance use disorders (SUD) are medical conditions often co-occurring with other medical conditions; and

Whereas, Integration of substance use disorder care with other medical care can help address health disparities, reduce health care costs for both patients and family members, and improve general health outcomes.[2]; and

Whereas, Well-supported scientific evidence shows that the traditional separation of substance use disorder treatment from mainstream health care has created obstacles to successful care coordination; and

Whereas, The continued separation of substance use disorder and general health care services has been costly, often harmful, and for some individuals even fatal. A recent study showed that the presence of a substance use disorder can double the odds that a person will develop another chronic and costly medical illness, such as arthritis, chronic pain, heart disease, stroke, hypertension, diabetes, or asthma.[3]; and

Whereas, The Federal Regulations mandating privacy protections for SUD treatment contained in 42 CFR Part 2 was intended to protect SUD patient records maintained in connection with certain programs or activities, but special SUD information protection may inadvertently reinforce stigma against patients by reinforcing the belief that SUD is different from other health

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[1]Center for Behavioral Health Statistics and Quality (CBHSQ). *2017 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2018.

[2] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

[3] Scott, K. M., Lim, C., Al-Hamzawi, A., Alonso, J., Bruffaerts, R., Caldas-de-Almeida, J. M., . . . de Jonge, P. (2016). Association of mental disorders with subsequent chronic physical conditions: World mental health surveys from 17 countries. JAMA Psychiatry, 73(2), 150-158.

problems and must be kept more private. In turn, this stigma may inhibit the delivery of comprehensive integrated care[4]; and

Whereas, The limited application of 42 CFR Part 2 to some substance use disorder treatment facilities and the discrepancies between HIPAA and Part 2 are serious issues affecting the integration and coordination of health care for patients with substance use disorders by contributing to a separation of substance use disorder specialty care[5]; therefore be it

RESOLVED, That our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings (New HOD Policy); and be it further

RESOLVED, That our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/10

RELEVANT AMA POLICY

Modernizing Privacy Regulations for Addiction Treatment Records H-315.965
Our AMA supports: (1) regulatory and legislative changes that better balance patients privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.
Citation: Res. 224, I-17

[4] Schaper E, Padwa H, Urada D, Shoptaw S. Substance use disorder patient privacy and comprehensive care in integrated health care settings. Psychol Serv. 2016 Feb;13(1):105-9.
[5] Hu LL, Sparenborg S, Tai B. Privacy protection for patients with substance use problems. Substance Abuse and Rehabilitation. 2011;2:227-233. doi:10.2147/SAR.S27237.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-19)

Introduced by: American Thoracic Society

Subject: COPD National Action Plan

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Chronic Obstructive Pulmonary Disease, or COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema, chronic bronchitis, and in some cases, asthma; and

Whereas, COPD is the fourth-leading cause of death in the US; and

Whereas, CDC reports that 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD; and

Whereas, CDC report that more than 50% of adults with low pulmonary function were not aware that they had COPD so the actual number of patients with COPD may be higher; and

Whereas, The following groups are more likely to have COPD:

- People aged 65 years and older.
- American Indian/Alaska Natives and multiracial non-Hispanics.
- Women.
- Individuals who were unemployed, retired, or unable to work.
- Individuals with less than a high school education.
- Individuals who were divorced, widowed, or separated.
- Current or former smokers.
- People with a history of asthma; and

Whereas, Congress was concerned about COPD in the U.S. and directed the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) to craft a comprehensive federal plan to tackle the disease; and

Whereas, In response to the Congressional request, the NIH's National Heart, Lung, and Blood Institute (NHLBI) collaborated with the CDC, other federal agencies, patient and provider organizations to develop a COPD National Action Plan; and

Whereas, NHLBI has publicly released the COPD National Action Plan that call for programs in five areas, including:

1. Empower people with COPD, their families, and caregivers to recognize and reduce the burden of COPD.
2. Improve the prevention, diagnosis, treatment, and management of COPD by improving the quality of care delivered across the health care continuum.

3. Collect, analyze, report, and disseminate COPD-related public health data that drive change and track progress.
4. Increase and sustain research to better understand the prevention, pathogenesis, diagnosis, treatment, and management of COPD.
5. Translate national policy, educational, and program recommendations into research and public health care actions; and

Whereas, Federal funding is needed to provide NHLBI and CDC funds to implement initial steps of the COPD National Action Plan; therefore be it

RESOLVED, That our American Medical Association support the inclusion of $25 million at NIH's National Heart, Lung, and Blood Institute (NHLBI) and an additional $2 million at the Centers for Disease Control and Prevention in the FY2020 Labor Health and Human Services and Education Appropriations Bill to implement the Chronic Obstructive Pulmonary Disease (COPD) National Action Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA send a letter to House and Senate Appropriators conveying its support for the COPD National Action Plan funding for fiscal year 2020. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/08/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-19)

Introduced by: Georgia

Subject: GME Cap Flexibility

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Projections by the Association of American Medical Colleges (AAMC) describe a deficit of 291,500 physicians by 2020 and 130,600[1]. According to the Georgia Physician Workforce, Georgia was ranked 39th in the nation for the number of practicing physicians per 100,000 people in 2016[2]. According to a report by the AAMC, Georgia would need to add nearly 1,500 new residency slots to match the national rate[2]; and

Whereas, New Graduate Medical Education teaching hospitals are allotted a five-year "cap window" allowing programs to increase the amount of residents in a program within that time frame, with the final amount of residents present in the fifth (and final) year of the" cap-building window" permanently determining the amount of funding from Medicare the program will receive, essentially "capping" Medicare funding, set by the Balanced Budget Act of 1997[3]; and

Whereas, Targeting support for GME programs by extending the cap-building window for new and existing teaching hospitals in rural, underserved, under- resourced communities and/or areas currently lacking medical training infrastructure will benefit our national GME system in many ways, including, but not limited to:
(a) Providing lifesaving opportunities for new teaching institutions to further develop residency programs and secure the resources necessary to launch and/or scale-up training capabilities. The additional time is vital to ensuring that teaching institutions in under resourced areas will be able to build-up to a level necessary to meet regional needs
(b) Alleviating regional physician shortages by providing time for institutions to add primary care and/or specialty and sub-specialty residencies in shortage;
(c) Boosting the return on investment for Medicare, local communities, states, medical schools, and the hosting teaching hospital.
(d) Helping address the disproportionate maldistribution of physicians and GME resources across the country[3]; and

Whereas, As residents tend to practice where they train, adding, developing, and incentivizing the establishment of programs at teaching institutions located in underserved, under-resourced, and rural areas will help address the current maldistribution of physicians across the country[3]; therefore be it

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[1] Association of American Medical Colleges. The impact of health care reform on the future supply and demand for physicians updated projections through 2025. https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf. Published June 2010. Accessed January 12, 2015.
[2] Association of American Medical Colleges. 2016 state physician workforce data book. https://www.aamc.org/download/484530/data/georgiaprofile.pdf
[3] Cap Flexibility: Putting GME Dollars to Work. Doctor's Hospital at Renaissance Health System , pp. 1–39, Cap Flexibility: Putting GME Dollars to Work.

RESOLVED, That our American Medical Association advocate for the Centers for Medicare and Medicaid Services (CMS) to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to primary care residencies (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where "Medicare funding does not begin until the first resident is 'on-duty' at the hospital." (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Additional Resources
4. Casey L., Gillanders W. R., Oprandi A. M., et al. Economic analysis of family practice residency programs: a report from the Northeastern Ohio Network. Fam Med. 1995;27(7):424–430. [PubMed]
5. Georgia Board for Physician Workforce. Georgia physician and physician assistant professions data book 2010/2011. https://gbpw.georgia.gov/sites/gbpw.georgia.gov/files/ related_files/site_page/2010-2011%20Physician%20and%20PA%20Data%20Book-Final. pdf. Published December 2013. Accessed January 12, 2015.
6. Kahn N. B., Pugno P. A., Brown T. C. Transferring sponsorship of a family practice residency: financial implications. Fam Med. 1991;23(8):620–623. [PubMed]
7. Nuss, Michelle A., and Peter F. Buckley. "Journal of the Medical Association of Georgia · October 2015." Georgia's innovative response to GME expansion, 28 Dec. 2015, pp. 10–11., https://www.researchgate.net/publication/283898723_Georgia%27s_innovative_response_to_GME_expansion.
8. Pauwels J. Three-year trends in the costs of residency training in family medicine. Fam Med. 2006;38(6):408–415. [PubMed]
9. Pugno, Perry A., William Ross Gillanders, and Stanley M. Kozakowski. "The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities." Journal of Graduate Medical Education 2.2 (2010): 154–159. PMC. Web. 7 Sept. 2017.
10. Saultz J. W., McCarty G., Cox B., Labby D., Williams R., Fields S. A. Indirect institutional revenue generated from an academic primary care clinical network. Fam Med. 2001;33(9):342–345. [PubMed]
11. Schneeweiss R., Ellsbury K., Hart L. G., Geyman J. P. The economic impact and multiplier effect of a family practice clinic on an academic medical center. JAMA. 1989;262(3):370–375. [PubMed]
12. University of Oklahoma Health Science Center. University of Oklahoma Health Science Center for Health Policy Research Report. Tulsa, OK: University of Oklahoma; 2002. Family medicine economic benefits of residency training programs.
13. Woodcock E. W. Assessing primary care's contribution to academic health centers. Med Group Manag J. 1999;46(2):14–18. [PubMed]

RELEVANT AMA POLICY

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.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-19)

Introduced by: Michigan

Subject: Improved Access to Non-Opioid Therapies

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The opioid epidemic has led to increased emphasis on non-opioid treatment approaches to pain; and

Whereas, In response to the opioid epidemic, several new laws were passed in the State of Michigan in 2017 and became effective in 2018 which have further reduced the accessibility of opioid-containing medications for the management of pain; and

Whereas, Research is increasingly showing that opioid therapy for chronic, non-malignant pain is ineffective and may lead to hyperalgesia; and

Whereas, Patients need access to non-opioid forms of treatment to help treat their chronic, non-malignant pain; and

Whereas, The sudden reduction in access to legally prescribed opioid-containing medications has been implicated as possibly contributing to the increased use of illegal heroin and synthetic opioid-containing medications; and

Whereas, Access to other proven modalities for effective pain treatment, such as physical therapy, occupational therapy, and complementary and alternative medicine therapies which are non-opioid treatment approaches, is of increasing importance in light of the sudden reduction in access to opioid-containing medications and gabapentin; and

Whereas, Third party payers and the Centers for Medicare and Medicaid Services (CMS) have not improved access to non-opioid treatment options for chronic pain through a reduction in co-payment fees, a reduction in prior authorization requirements, a reduction in required prior treatments, and/or an expanded list of acceptable indications for the various therapies; and

Whereas, This lack of improved access is leading to increased patient dissatisfaction, decreased ability for physicians to provide adequate care for their patients with chronic pain or any type of pain, possible increased use of illicit drugs by chronic pain patients as a way to cope, and possible increased opioid-related overdose deaths as a result of the sudden reduction in access to legally prescribed opioid-containing medications; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to improve access to non-opioid treatment modalities including, but not limited to, physical therapy and occupational therapy as recommended by the patient's physician. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Workforce and Coverage for Pain Management H-185.931
1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
Citation: CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18

Alternative Medicine H-480.964
Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment.
Citation: (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02; Modified: CSAPH Rep. 1, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-19)

Introduced by: Michigan

Subject: Prescription Coverage of the Lidocaine Transdermal Patch

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The opioid epidemic has led to an increased focus on non-opioid-containing medications to treat pain, especially chronic, non-malignant pain; and

Whereas, Research is increasingly showing that opioid therapy for chronic, non-malignant pain is ineffective and may lead to hyperalgesia; and

Whereas, Topical lidocaine is effective for the treatment of pain; and

Whereas, Topical lidocaine has minimal side effects and is generally well tolerated; and

Whereas, Topical lidocaine is available over the counter in cream and transdermal patch forms; and

Whereas, Lidocaine as a transdermal patch is an effective, topical pain treatment which may be a reasonable alternative to opioid-containing medications; and

Whereas, Transdermal lidocaine has only one Food and Drug Administration-approved indication for use as a prescribed medication (for the treatment of post-herpetic neuralgia) with related limitations in insurance coverage; and

Whereas, Third-party payers will not provide prescription coverage for this medication for any off label uses; and

Whereas, Other medications are occasionally covered by third party payers for off label uses if other effective treatment options are unavailable or have limited availability; and

Whereas, Opioid and controlled substance laws and application of the Centers for Disease Control and Prevention safe opioid prescribing guidelines are making access to opioid-containing and non-opioid containing medications for the treatment of pain more limited; therefore be it

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches (Directive to Take Action); and be it further

RESOLVED, That our AMA urge the Centers for Medicare and Medicaid Services and third-party payers to provide insurance coverage of lidocaine transdermal patches for other indications in addition to post-herpetic neuralgia. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Workforce and Coverage for Pain Management H-185.931
1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
Citation: CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-19)

Introduced by: Medical Student Section

Subject: Support for Universal Basic Income Pilot Studies

Referred to: Reference Committee B
(Charles Rothberg, MD, 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 provides every citizen over the age of 18, regardless of income, with enough income to live just above the poverty line[8-9]; and

Whereas, Need-based assistance legislation does not address racial disparities, and differences in policy across different states can worsen disparities[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 mitigated or eliminated entirely[14]; and

Whereas, It is estimated that currently demonstrated technology has the capability to automate 45% of tasks workers are paid to perform and Universal Basic Income could protect workers from financial insecurity from future technological job elimination[15-18]; and

Whereas, Multiple studies have shown that cash transfer programs have led to health and education benefits, including reduction in hospitalizations, increased organ function, decreased incidence of psychiatric disorders and alcohol use, and increased educational attainment[19-25]; and

Whereas, Universal Basic Income could provide the benefits of a cash transfer program, and may address one of the greatest flaws of a cash transfer program, which is that they have not been shown to have a significant 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 considers social determinants of health, including poverty, to be a significant predictor of health outcomes, supports their inclusion in the medical school curriculum (H-295.874), and encourages screening for these determinants to improve patient care (H-160.909); 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 American Medical Association support 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. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

References:

1. Social Determinants of Health. Office of Disease Prevention and Health Promotion, 2018, www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health#two.
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RELEVANT AMA POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.
Citation: 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.
Citation: 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.
Citation: 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; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-18

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.
Citation: (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.
Citation: (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.
Citation: (Res. 424, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-19)

Introduced by: Medical Student Section

Subject: Opportunities in Blockchain for Healthcare

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Blockchain is a distributed database that stores records of all transactions and digital events carried out by its participants, called the public ledger, hosted across all participants (nodes), rather than a central entity[1]; and

Whereas, Once something has been added to the blockchain, it is permanently stored across all nodes, and in this way, blockchain functions as a decentralized, immutable ledger capable of storing data without the need for a central responsible entity, mitigating risk from central failure[2-4]; and

Whereas, Blockchain may alleviate several pain points in the current state of information sharing in health information technology, for example, allowing multiple stakeholders to agree on the "true" state of data (immutable ledger), helping decrease administrative costs regarding authorization and claims adjudication, better defining data ownership, and reducing unauthorized data use through less burdensome computer code[9,10]; and

Whereas, The 21st Century Cares Act defines health information technology (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" [6]; and

Whereas, Interoperability positively impacts health systems in a variety of ways; including by increasing operational efficiency, reducing clinical duplication/waste, and enhancing clinical care by providing access to longitudinal data at the point of care[7]; and

Whereas, There has been a concerted effort, including through the AMA-driven Integrated Health Model Initiative, to develop data structures that promote data sharing and standardize output of data from proprietary EHRs to facilitate interoperability[6-8]; and

Whereas, In considering the security advantages and risks of blockchain technology compared to contemporary approaches, each pillar of HIPAA (Administrative, Physical, Technical) must be assessed under more precise definitions of security: Confidentiality and Unforgeability[4]; and

Whereas, Several case studies have shown that blockchain can mitigate risks related to mobile data communication with EHRs through the use of smart contracts[12,13]; and

Whereas, 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[13]; and

Whereas, 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; and

Whereas, It is recognized that blockchain remains an early stage technology, but one with the potential through technical innovation to rapidly overcome existing drawbacks health information technology interoperability faces today; and

Whereas, To date, the AMA does not have explicit policy on blockchain technology; therefore be it

RESOLVED, That our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it further

RESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

HIPAA Law And Regulations D-190.989
(1) Our AMA shall continue to aggressively pursue modification of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to remove burdensome regulations that could interfere with efficient patient care.
(2) If satisfactory modification to the HIPAA Privacy Rule is not obtained, our AMA shall aggressively pursue appropriate legislative and/or legal relief to prevent implementation of the HIPAA Privacy Rule.
(3) Our AMA shall continue to oppose the creation or use of any unique patient identification number, including the Social Security number, as it might permit unfettered access by governmental agencies or other entities to confidential patient information.

(4) Our AMA shall immediately begin working with the appropriate parties and trade groups to explore ways to help offset the costs of implementing the changes required by the Health Insurance Portability and Accountability Act so as to reduce the fiscal burden on physicians.
Citation: (Sub. Res. 207, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12

HIPAA Requirements for E-Commerce in Health Care D-478.998
Our AMA will: (1) intensify its on-going effort to inform practicing physicians about the consequences of implementation (including financial implications) of the Health Insurance Portability and Accountability Act (HIPAA) regulations for transmission of electronic information; and (2) study strategies on implementation of the HIPAA regulations, such as a limit on the frequency of modifications, which will lessen the financial impact on physicians, with a report back to the AMA House of Delegates when final regulations are promulgated.
Citation: (Res. 802, A-00; Reaffirmed: BOT Rep. 6, A-10

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.
Citation: (Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12

Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973
1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:
a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.
Citation: (CMS Rep. 6, I-06; Reaffirmed: BOT Rep. 17, A-13

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 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.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.
Citation: BOT Rep. 19, A-18

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.
Citation: (Res. 723, A-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 237, A-12

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;
(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; and
(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-19)

Introduced by: North American Neuromodulation Society

Subject: Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, There is a worsening opioid crisis in the United States and in 2017 there were more opioid related deaths than all other drugs, motor vehicle accidents, firearm related deaths, or suicides (1); and

Whereas, According to the Centers for Disease Control (CDC) more than 68% of the 70,200 drug overdose deaths in 2017 involved an opioid (2); and

Whereas, Significant initiatives by the CDC and state medical boards to curb the prescription of opioids has so far not resulted in a decrease in opioid related deaths (3); and

Whereas, The decreased availability of prescription opioids has contributed to an increase in the use of illicit opioids including heroin, and heroin laced with fentanyl, causing an increased number of unintentional deaths (4); and

Whereas, The marked decrease in the utilization of interventional pain procedures from 2009-2017 secondary to an increase in regulations and requirements regarding these procedures, has directly correlated with the increase in opioid related deaths during the same duration, and this is an ongoing public health crisis (5); and

Whereas, Current AMA policy supports quality care for patients with pain including patient access to non-opioid and interventional pain management treatments (H-185.931); supports timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care (D-450.956); is committed to better access and delivery of quality pain care including through clinical practice (D-160.931); and opposes legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence- based, comprehensive pain care (H-95.930); and

Whereas, There are multiple evidence based guidelines and studies regarding the effectiveness of interventional pain procedures based on prospective cohort and/or randomized controlled trials including but not limited to: sacroiliac joint blocks and radiofrequency ablation (6-12), medial branch blocks and radio frequency ablation (for cervical, thoracic and lumbar facet arthritis) (13-17), genicular nerve blocks and radiofrequency ablation (for non-operable knee arthritis or pain) (18-22), femoral and obturator nerve blocks and radiofrequency ablation (for non-operable hip arthritis or pain) (23, 24), suprascapular nerve blocks and radiofrequency ablation (for non- operable shoulder arthritis or pain), spinal cord and peripheral nerve stimulation; yet limitations and noncoverage decisions for these as well as many other interventional pain management procedures by multiple private insurance carriers, third party

review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans exist, which have no regard to the basis and variability in severity of patient spine, nerve, and joint pathology or patient presentation (6-10); and

Whereas, There is non-inclusion of many diagnoses and conditions which have been to shown to be of benefit with regards to spinal cord stimulation and peripheral nerve stimulation that multiple private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans are omitting from their coverage policies; therefore be it

RESOLVED, That our American Medical Association support coverage of sacroiliac joint blocks and radiofrequency ablation, facet (spine joint) medial branch blocks and radiofrequency ablation, genicular blocks and radiofrequency ablation for non-operable knee arthritis or pain, femoral and obturator nerve blocks and radiofrequency ablations for non-operable hip arthritis or pain, suprascapular nerve blocks and radiofrequency ablations for non-operable shoulder arthritis or pain, and other arbitrarily limited non-covered interventional pain management procedures, by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans (Directive to Take Action), and be it further

RESOLVED, That our AMA support coverage of spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans by ICD-10 codes that have been linked to the respective Current Procedural Terminology (CPT) code set as outlined in the AMA CPT Manual. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Workforce and Coverage for Pain Management H-185.931

1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable.
Citation: CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18

Pain as the Fifth Vital Sign D-450.956
Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics.
Citation: BOT Rep. 19, A-16

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; 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. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA 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. Our AMA 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.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

Legislative Pain Care Restrictions H-95.930
Our AMA will oppose legislative or other policies that arbitrarily restrict a patient's ability to receive effective, patient-specific, evidence-based, comprehensive pain care.
Citation: Res. 228, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-19)

Introduced by: Gregory Pinto, MD, Delegate

Subject: Improving Access to Medical Care Through Tax Treatment of Physicians

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, Independent physician practices, which employ many people and provide an excellent service to their communities and are vital to a viable medical profession have been going out of business at a record pace in the last 5 years because physicians cannot get adequately reimbursed to stay in practice; and

Whereas, The recent federal tax reform act of 2018 was meant specifically to help small businesses stay in business, recognizing their importance and value in a healthy economy; and

Whereas, The recent federal tax law allowed many small businesses, including small business professionals of certain professions such as real estate, architecture, and engineering to have their company “pass through” income taxed at the lower capital gains rates (rather than the higher personal income rates), but physicians were specifically excluded from this benefit; and

Whereas, One reason physicians are turning over their practices to corporations is that through a sale they can take advantage of the lower capital gains tax rates, so there is a paradoxical incentive towards fostering the corporate practice of medicine; and

Whereas, Non-physician providers, such as hospitals, can usually apply for emergency Medicaid or indigent funding to help cover their costs; therefore be it

RESOLVED, That our American Medical Association seek legislation and/or regulation that would permit physician practices to utilize ‘pass through’ tax treatment of practice income in the manner of other small businesses and professionals. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

The Preservation of the Private Practice of Medicine D-405.988
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; and (7) will

create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
Citation: Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation I-13; Appended: Res. 735, A-14; Reaffirmed in lieu of Res. 223, I-14; Modified: Speakers Rep. 01, A-17

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice. Citation: CME Rep. 04, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-19)

Introduced by: Hawaii

Subject: Formation of Collective Bargaining Workgroup

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The mission of the AMA and affiliated state medical associations is to promote the art and science of medicine, and the betterment of public health; and

Whereas, There is a current consolidation of the health insurance markets wherein 73% of markets are highly concentrated and 46% have a single predominant carrier with greater than 50% of the market; and

Whereas, These predominant carriers control the market to the extent that independent physician practices cannot survive if they do not participate with these carriers; and

Whereas, These carriers are unilaterally establishing practice algorithms and reporting requirements which direct the physician work environment; and

Whereas, There is increasing national sentiment toward the development of a single payer health care system; and

Whereas, Independent physicians are currently barred from collective bargaining activities by federal antitrust law; therefore be it

RESOLVED, That our American Medical Association form a workgroup to outline the legal challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further

RESOLVED, That this workgroup engage the state medical associations and other physician groups as deemed appropriate (Directive to Take Action); and be it further

RESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy for the formation of a federal collective bargaining system for all physicians and, to the extent viable, a related organizational plan. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.
Citation: (Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10

Collective Bargaining and the Definition of Supervisors D-383.988
Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al*.
Citation: (BOT Action in response to referred for decision Res. 248, A-01; Modified: BOT Rep. 22, A-11

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.
Citation: (BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12

Collective Bargaining: Antitrust Immunity D-383.983
Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.
Citation: BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.
Citation: (Res. 229, A-12

Employee Associations and Collective Bargaining for Physicians D-383.981
Our AMA will study and report back on physician unionization in the United States.
Citation: (Res. 601, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Facilitation of Research with Medicare Claims Data

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

Whereas, The achievement of the Quadruple Aim of enhancing patient and clinician experience of care, improving population health, and reducing costs requires evaluation and analysis of data related to patient care; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) is pursuing the achievement of the Quadruple Aim through alternative payment programs, some of which involve Accountable Care Organizations (ACO), networks of providers who take responsibility for the quality and cost of care of a specified population; and

Whereas, Medicare claims data is provided to and collected by ACOs, that are combinations of HIPAA Covered Entities working together in order to advance the coordination of care as a core strategy to increase quality of care and decrease cost of care; and

Whereas, ACOs, as Business Associates of the Covered Entities in their networks, are bound by HIPAA and Business Associate Agreements; and

Whereas, Opportunities to assess the impact of ACO interventions are lacking if the data cannot be shared for research; and

Whereas, The Data Use Agreement (DUA) used by CMS's Centers for Medicare and Medicaid Innovation (CMMI) for value based payment programs such as shared savings and Next Generation, limits the use of data provided by CMS to ACOs and other users; and

Whereas, The restrictions in a DUA are generally intended to align with the objectives for the data sharing, such as, for example, developing care models through ACOs that improve quality and decrease costs; and

Whereas, The limitations in the DUA are greater than those posed by HIPAA that allows use of similar data for research with full privacy protections and, therefore, the DUA poses an additional barrier to research; and

Whereas, The DUA requires an ACO to obtain prior written authorization from CMS to disseminate original or derived information from the files CMS shares with the ACO to anyone who is not an ACO Participant, a Business Associate of an ACO Participant or a Covered Entity in a treating relationship with the patient; and

Whereas, This limitation significantly impedes the ability of researchers to evaluate the efficacy of ACO interventions and to investigate population health questions by impeding both: (1) the

ability to produce and use de-identified data sets as permitted by HIPAA and (2) the use of Medicare claims data held by ACOs for research as permitted by HIPAA; and

Whereas, In the current situation, ACOs may use CMS data for internal quality improvement initiatives, but may not share their results in the descriptive, observational quality improvement literature; and

Whereas, ACOs, governmental payers, academics, health care providers, academics and patients would benefit from efficacy and other research; and

Whereas, The improvement of quality, cost, and patient satisfaction are all advanced by quality improvement literature; therefore be it

RESOLVED, That our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, request that the Centers for Medicare and Medicaid Services (CMS) and CMS's Centers for Medicare and Medicaid Innovation (CMMI) eliminate the prohibitions on sharing data outside of the accountable care organization contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by HIPAA; and (2) for purposes of research as permitted by HIPAA. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

RELEVANT AMA POLICY

Medicare Claims Data Release D-406.993
Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to identify appropriate modifications to improve the usefulness and accuracy of any existing or future provider-specific data released by that agency; (2) engage with data experts and other stakeholders to develop guiding principles on the data and transparency efforts that should be pursued in order to assist physicians to improve the quality of care and reduce costs; and (3) petition the Centers for Medicare & Medicaid Services and the Office of Health & Human Services to remove practice expense and malpractice expense from reimbursements reported to the public.
Citation: Sub. Res. 204, A-14; Appended: Res. 226, A-17

Sharing Demographic Medicare Data with Other Public Entities by CMS H-330.934
The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.
Citation: Sub. Res. 810, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Medicare Physician Payment Reform D-390.961
1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.

4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congre ss and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.
Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

Accountable Care Organization Principles H-160.915
Our AMA adopts the following Accountable Care Organization (ACO) principles:
1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.
A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.
B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.
A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.
11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.
Citation: Res. 819, I-10; Reaffirmation A-11; Reaffirmed: Res. 215, A-11; Reaffirmation: I-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: Sub. Res. 711, A-15; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmation: I-17

Reference Committee C

BOT Report(s)

25 All Payer Graduate Medical Education Funding

CME Report(s)

01 Council on Medical Education Sunset Review of 2009 House Policies
02 Update on Maintenance of Certification and Osteopathic Continuous Certification
03 Standardizing the Residency Match System and Timeline
04 Augmented Intelligence in Medical Education
06 Study of Medical Student, Resident, and Physician Suicide

Joint Report(s)

01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure

Resolution(s)

301 American Board of Medical Specialties Advertising
302 The Climate Change Lecture for US Medical Schools
303 Graduate Medical Education and the Corporate Practice of Medicine
304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs
305 Lack of Support for Maintenance of Certification
306 Interest Rates and Medical Education
307 Mental Health Services for Medical Students
308 MOC Moratorium
309 Promoting Addiction Medicine During a Time of Crisis
310 Mental Health Care for Medical Students
311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure
312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians
313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes
315 Scholarly Activity by Resident and Fellow Physicians
316 Medical Student Debt
317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
318 Rural Health Physician Workforce Disparities
319# Adding Pipeline Program Participation Questions to Medical School Applications
320# Opioid Education in Medical Schools
321# Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession
322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-A-19

Subject: All Payer Graduate Medical Education Funding

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which asks that our AMA:

> …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.

BACKGROUND

An Overview of Graduate Medical Education

Graduate medical education (GME) programs account for nearly three-quarters of the U.S. Department of Health & Human Services' (HHS) health workforce expenditures, and may be a strong policy lever to impact patient access to care because the number of medical school graduates who obtain and complete a residency determines the size of the physician workforce and the types of residencies they complete determine its specialty composition.[1] Also, where physicians complete their residencies often affects where they establish their practices.[2] As a result, policies that alter federal funding for GME may impact future physician supply and could be used to address certain workforce concerns.

Although the federal government is not the sole contributor to GME funding, it is by far the largest single source, primarily through Medicare funding. Medicare funding to support GME programs comes from direct GME funding and indirect GME funding. Direct GME (DGME) funding represents approximately one-third of all Medicare support for GME. It supports the direct costs of running a residency program and covers salaries for residents and faculty as well as educational support. Indirect GME payments (IME), which represent the majority of Medicare GME funding, are calculated based on the size of a hospital, the number of residents supported, and the number of Medicare inpatients treated. IME payments are in addition to payments an institution receives from Medicare reimbursement and are meant to offset the costs of maintaining an educational program that are not captured by Medicare reimbursement. Both IME and DGME payments are derived by complex formulas and are not designed to account for differences in costs resulting from training residents of different specialties. The Department of Veterans Affairs, Medicaid, and the Children's

Health Insurance Program are other federal sources of GME funding of varying levels. In addition, the Army, Navy, and Air Force support their own in-house residencies and fellowships to provide for the future physician workforce needs of those services.

Federal Funding for Graduate Medical Education[3]

Program Name *Control over trainees*	**Total Funding**	**Number of Trainees**	**Cost Per Trainee**
MANDATORY FUNDING			
Medicare GME Payments *The number of Medicare-supported residents and per-resident payment amount is capped for each hospital, but hospitals determine staffing needs and types of residents with the exception of certain primary care residents.*	FY2015 (est.): $10.3 - $12.5 billion	FY2015 (est.): 85,712 - 87,980 FTE (DGME) slots 85,578 - 88,416 FTE (IME) slots	FY2015 (est. average): $112,000 - 129,000 per FTE
Medicaid GME Payment *States are permitted to make these payments using their own criteria to determine which providers are eligible for payments.*	N/A.	N/A The Medicaid program does not require states to report these data.	N/A. The Medicaid program does not require states to report these data.
Teaching Health Centers GME Payment Program *Funding to applicant teaching health centers that meet the program's eligibility requirements.*	FY2018: $126.5 million (est.)	AY2016-AY2017: 742 FTE slots 771 total residents trained	N/A.
DISCRETIONARY FUNDING			
Veterans Affairs GME Payments *VA facilities determine their staffing needs and the number and type of residents supported.*	FY2017: $1.78 billion	AY2016-AY2017: 11,000 FTE slots and > 43,565 residents spent part of their training at a VA facility	FY2015 (est.): $137,792/resident
Children's Hospital GME Payment Program *Grant funding awarded to applicant children's hospitals that meet the program's eligibility requirements.*	FY2019: $325bmillion	FY2016-FY2017 58 hospitals received payments to support 7,164 FTE slots	N/A
Department of Defense GME Payments *Divisions of the armed forces determine their staffing needs and the number and type of residents supported.*	FY2012: $16.5 million	FY2017: 3,983 FTE residents	N/A

Source: CRS analysis of agency data, including review of various agency budget justification and The Robert Graham Center program data sourced from CMS Medicare hospital cost report data, and GAO report, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* (GAO-18-240, 2018).

Notes: AY = Academic year; Academic year 2016-2017 began on July 1, 2016, and concluded on June 30, 2017. DGME = direct graduate medical education. est. = estimate. FTE = full time equivalent. FY = fiscal year. IME = Indirect Medical Education. N/A = not available. VA = the Department of Veterans Affairs.

Data on Medicaid GME funding are limited. The Centers for Medicare & Medicaid Services (CMS) began collecting information about Medicaid GME payments made through the fee-for-service delivery system in FY2010 through the CMS-64 data. Other information about Medicaid GME payments is available from the Association of American Medical Colleges (AAMC) and U.S. Government Accountability Office (GAO). AAMC conducts a 50-state survey about Medicaid GME payments every two to three years. According to AAMC's 2016 50-state survey, in 2015, the overall level of support for GME continued to grow, reaching $4.26 billion. This represents a significant increase since 1998, when Medicaid GME support totaled $2.3–$2.4 billion. However, three states reported in 2015 that they explicitly reduced GME payments; another seven states reported their total 2015 GME payments decreased by 10 percent or more over 2012 levels.[4]

The Medicare GME Caps

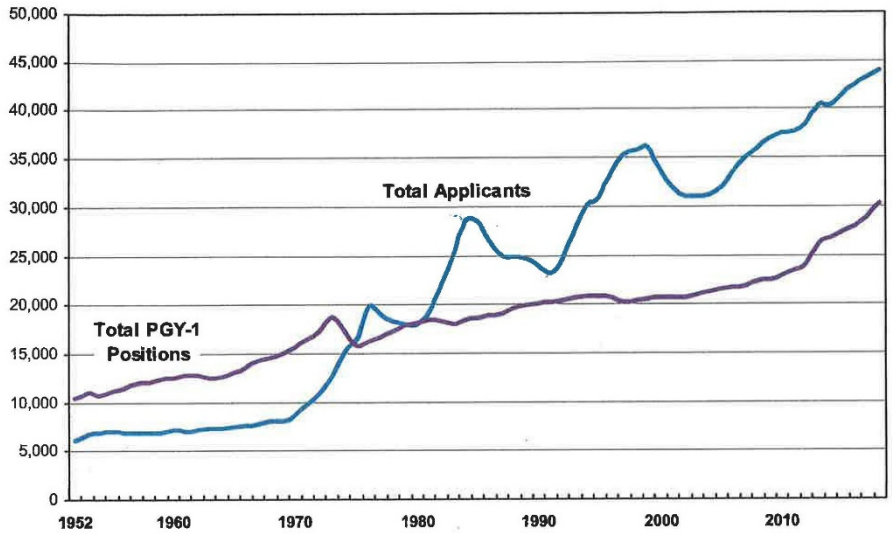
Medicare's GME support was initially open-ended, where Medicare would pay for additional full time equivalent (FTE) residents that hospitals trained. In 1997, GME stakeholders released a consensus statement arguing that the United States was on the verge of a serious oversupply of physicians and recommending limiting federal funding of GME positions to more align with the

number of graduates of accredited U.S. medical schools.[5] Congress enacted the Balanced Budget Act of 1997, (P.L. 105-33), which limits Medicare's GME—most hospitals would receive DGME and IME support only for the number of allopathic and osteopathic FTE residents it had in training in 1996; in other words, the number of positions Medicare supported in each hospital in 1996 was established as the upper limit in terms of the number of positions or slots that Medicare would fund in those institutions thereafter. Slots, which may be occupied by residents or fellows, do not directly correspond to a specific individual, as residents or fellows may spend periods of a given year at different facilities, or doing research. Residents may not be counted simultaneously for payment by two government programs. Therefore, when residents are located at different facilities, they are not counted by the sponsoring hospital.

The Medicare cap is not absolute. Medicare provides GME funding to newly constructed hospitals that introduce residency programs and to existing hospitals that did not previously sponsor residency training. Furthermore, the GME cap is not calculated and implemented until new teaching programs' fifth year; this is meant to offer institutions time to build and scale their programs to appropriate levels.

Since the Medicare cap was enacted, hospitals have expanded the number of residents they are training by using non-Medicare sources of support (e.g., hospital, state, or local funds). Specifically, in the 20 years since the cap was enacted, the number of residency slots has increased by approximately 27 percent. Generally, these increases have been in subspecialties (i.e., for fellowship training); subspecialty services tend to generate higher revenue or impose lower cost burden on hospitals. In addition, Medicare GME slots have been redistributed since the cap was enacted. For example, the Affordable Care Act included two redistribution programs—the first redistributed unused slots, and the second continually redistributes slots from closed hospitals. However, caps on the number of resident trainees imposed by Medicare continue to further restrict the number of residency positions offered and provide teaching hospitals with little flexibility for expansion.

Figure 1 **Applicants and 1st Year Positions in the Match, 1952 - 2018**



Source: https://mk0nrmpcikgb8jxyd19h.kinstacdn.com/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2018.pdf

Furthermore, based on the projected physician shortfall that is expected by 2030, the cap established in 1997 is outdated and will continue to cause stress on a health care system already

beginning to show signs of strain in communities lacking sufficient numbers of physicians to care for individuals living in these rural and underserved areas. It is projected that physician demand will grow faster than supply, leading to a projected total physician shortfall of between 42,600 and 121,300 physicians by 2030. A primary care shortage of between 14,800 and 49,300 physicians is projected by 2030. With regard to non-primary care specialties, a projected shortfall of between 33,800 and 72,700 physicians is expected, including a shortfall of between 20,700 and 30,500 physicians in 2030 for surgical specialties. Major drivers of these projected trends continue to be an aging population requiring increasingly complex care concomitant with an aging physician workforce.[6]

DISCUSSION

AMA Advocacy

For more than a decade, the AMA has advocated for the modernization of GME, calling for increased funding for medical residency slots, development of innovative practice models as well as residency positions that reflect societal needs. Below is an overview of recent advocacy efforts by the AMA in this area. The advocacy efforts detailed below were taken by the AMA in accordance to and in concert with the policy directives outlined in AMA Policy D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," and Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education."

Congressional Advocacy

The AMA advocated in support of the following federal bills that were introduced during the 115th Congress (2017-2018):

- The Advancing Medical Resident Training in Community Hospitals Act of 2017 (S. 1291/H.R. 4552) – The bill would have closed a loophole in GME cap-setting criteria affecting hospitals who host small numbers of residents for temporary training assignments. The AMA submitted a support letter in June 2018.
- The Resident Physician Shortage Act of 2017 (S. 1301/H.R. 2267) – The bill would have provided 15,000 additional Medicare-supported GME positions over five years. The AMA submitted a support letter in June 2017.
- The Teaching Health Centers Graduate Medical Education (THCGME) Extension Act of 2017 (S. 1754/H.R. 3394) – The bill would have reauthorized the THCGME program for an additional three years and support program expansion to serve more rural and underserved communities. The AMA submitted a support letter in September 2017.
- The Conrad 30 and Physician Access Reauthorization Act (S.898/H.R.2141) – The bill would have reauthorized the J-1 visa waiver program for an additional three years, protecting patient access to care in medically underserved areas across the United States. The AMA submitted a support letter in May 2017. In 2013 and 2015, the AMA also actively supported legislation to reauthorize Conrad 30.
- Opioid Workforce Act of 2018 (S.2843/H.R. 5818) – The bill would have increased the number of residency positions eligible for GME under Medicare for hospitals that have addiction or pain management programs, with an aggregate increase of 1,000 positions over a five-year period. The AMA submitted a support letter in June 2018.

The AMA is advocating for the following federal bills that have been introduced during the 116th Congress (2019-2020):

- The Community and Public Health Programs Extensions Act (S. 192) – The bill would reauthorize $310M for the National Health Service Corps, $126M for THCGME programs, and $4B for Community Health Centers for each fiscal year from 2019 to 2024. The AMA has submitted a support letter.
- Rural Physician Workforce Production Act of 2019 (S. 289) **–** The bill would establish a national per resident payment amount in order to make accepting residents a financially viable option for rural hospitals.
- Training the Next Generation of Primary Care Doctors Act of 2019 (S. 304) – The bill provides funding for current THCGME programs and supports and funds the creation of new programs and/or centers, with a priority for those serving rural and medically underserved populations and areas.
- Resident Physician Shortage Reduction Act of 2019 (S. 348) – The bill would provide 15,000 additional Medicare-supported GME positions over five years. The AMA has submitted a support letter.

The Compendium of GME Initiatives

- The AMA has long-focused on ways to improve GME to ensure medical students can fulfill training requirements and become practicing physicians. The "Compendium of Graduate Medical Education Initiatives" was created and distributed in 2016. It provides background regarding the challenges faced by the current GME system and GME initiatives, including those by the AMA, private, and state-based stakeholders. It also provides a snapshot of AMA's advocacy efforts through 2016. The GME Compendium will be updated in 2019 to include relevant federal and state legislation, regulatory proposals, and state-based initiatives that have emerged since 2016. The updated version will also reflect any changes in AMA HOD policy.

Cap-Flexibility

- GME cap-flexibility is an emerging policy concept which calls for targeted policy efforts to provide new teaching hospitals in underserved areas flexibility and additional time in establishing Medicare-funded GME caps. In October 2017, in accordance with AMA policy D-305.967 (31), the AMA advocated in a letter to CMS that the agency provide for more flexibility in the graduate medical education cap-setting deadline, particularly for new residency programs in underserved areas and/or economically-depressed areas.

Reimagining Residency

- In 2013, the AMA instituted the "Accelerating Change in Medical Education" initiative by making grants to medical schools to support undergraduate medical education innovation. "Reimagining Residency" is the next phase in this initiative. The aim of this five-year $15-million grant program is to significantly improve GME through bold, rigorously evaluated innovations that align residency training with the needs of patients, communities and the rapidly changing health care environment. Funding will be provided to U.S. medical schools, GME programs, GME sponsoring institutions, health systems and other organizations associated with GME to support bold and innovative projects that promote systemic change in graduate medical education.

SaveGME.org

- The AMA created the SaveGME.org webpage in 2013 as a grassroots advocacy platform that medical students and residents could use to apply pressure to lawmakers in favor of preserving

essential funding for GME. In 2017, the SaveGME.org website was updated to include public-facing messaging and educational materials. To date, more than 3,000 medical students and residents have taken action via SaveGME.org to urge their members of Congress not to make cuts to GME.

2019 Medical Student Advocacy & Region Conference (MARC)

- Each year, approximately 400 medical students participate in the MARC and advocate for increased GME funding. Medical students learn about relevant legislation and lobby their Members of Congress on Capitol Hill in Washington, DC.

Increased Accountability and Transparency to Support Increased GME Funding

The federal government supports workforce data collection and projections of future needs. In addition, researchers and advocates also collect and disseminate such data. Such data are necessary inputs for GME policy but are not sufficient to comprehensively determine whether the federal investment in GME training meets national physician workforce needs. The information agencies collect is not always complete or consistent within or across programs. For example, national data on GME training costs are not systematically collected, and some agencies lacked data to determine the total amount spent or the outcomes of their programs, such as where supported residents went on to practice. Furthermore, HHS currently cannot target Medicare GME funding to specific areas of workforce need because funds are disbursed based on a statutory formula that is unrelated to projected needs.[7] The AMA agrees with the GAO that comprehensive information is needed to identify gaps between federal GME programs and national physician workforce needs—particularly the distribution of physicians geographically or across specialties—and to recommend to Congress and the Administration changes to improve the efficient and effective use of federal funds to meet those needs.[8,9] Therefore, it is recommended that AMA Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," be amended to call on the AMA to encourage HHS to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs.

CONCLUSION

The AMA has extensive policy in support of a broad spectrum of GME-related issues and remains a strong advocate for the modernization and increased funding of GME. The AMA will continue to advocate for legislation that removes the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 and increases support and funding for GME programs in the U.S. The AMA will also update the "Compendium of Graduate Medical Education Initiatives" to reflect current proposals related to GME. Furthermore, the Board recommends the adoption of additional policy to encourage the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs.

RECOMMENDATIONS

1. The Board recommends that our AMA amend Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," with the addition of a new clause to read as follows, and that the remainder of the report be filed:

   Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs. (Modify Current HOD Policy)

2. That our AMA rescind section 33 of Policy D-305.967, which directed the AMA to conduct the study herein. (Rescind HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] Congressional Research Service (CRS), Federal Support for Graduate Medical Education: An Overview, pg. 1, December 27, 2018, https://fas.org/sgp/crs/misc/R44376.pdf
[2] Id.
[3] Id.
[4] Medicaid Graduate Medical Education Payments: A 50-State Survey (2016), https://members.aamc.org/eweb/upload/Medicaid_Graduate_Medical_Education_Payments--A_50_State_Survey.docx.pdf
[5] Consensus Statement on the Physician Workforce. Paper issued at a joint press conference, February 28, 1997, Washington, D.C.; and Association of Academic Health Centers subsequently testified before Congress regarding the Consensus Statement.
[6] AAMC, 2018 Update: The Complexities of Physician Supply and Demand: Projections from 2016 to 2030, https://aamc-black.global.ssl.fastly.net/production/media/filer_public/85/d7/85d7b689-f417-4ef0-97fb-ecc129836829/aamc_2018_workforce_projections_update_april_11_2018.pdf.
[7] GAO, Health Care Workforce: Comprehensive Planning by HHS Needed to Meet National Needs, December 11, 2015, https://www.gao.gov/assets/680/674137.pdf
[8] GAO, Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding, March 2018, https://www.gao.gov/assets/700/690581.pdf
[9] A May 2017 GAO report, found that there is an uneven distribution of residents across the country, with most concentrating in certain urban centers and the northeast, where GME training programs have historically been located; See GAO, Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs, https://www.gao.gov/assets/690/684946.pdf

RELEVANT AMA POLICIES

D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs"
Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: (a) ensure adequate Medicaid and Medicare funding for graduate medical education; (b) ensure adequate Disproportionate Share Hospital funding; (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions; (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings; (e) stabilize funding for pediatric residency training in children's hospitals; (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need; (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.
CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmation I-07 Reaffirmed: Res. 921, I-12 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13

D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"
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.
Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep, 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18 Reaffirmed in lieu of: Res. 960, I-18

D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy"
1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. 2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. 3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. 4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. 5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians. 6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.
Sub. Res. 314, A-09 Appended: Res. 316, A-12 Reaffirmed: Res. 921, I-12 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13

H-310.917, "Securing Funding for Graduate Medical Education"
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

CME Rep. 3, I-09 Modified: CME Rep. 15, A-10 Reaffirmed in lieu of Res. 324, A-12 Reaffirmed: CME Rep. 5, A-13 Appended: CME Rep. 1, I-15

H-305.988, "Cost and Financing of Medical Education and Availability of First-Year Residency Positions"
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education; 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future; 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced; 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained; 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are; 6. supports continued study of the relationship between medical student indebtedness and career choice; 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds; 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs; 9. encourages for profit-hospitals to participate in medical education and training; 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians; 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and 12. will advocate that resident and fellow trainees should not be financially responsible for their training.
CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16

H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage"
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program. H. 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. I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. J. Our AMA continue to conduct research

and monitor other progress in development of educational strategies for alleviating rural physician shortages. K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. 2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency. 3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
CME Rep. C, I-90 Reaffirmation A-00 Reaffirmation A-01 Reaffirmation I-01 Reaffirmed: CME Rep. 1, I-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 956, I-18

H-200.954, "US Physician Shortage"
Our AMA: (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US; (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties; (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations; (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations; (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas; (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need; (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16

D-310.977, "National Resident Matching Program Reform"
Our AMA: (1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process; (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match; (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match; (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises; (5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians; (6) does not support the

current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process; (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas; (10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers; (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs; (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs; (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program; (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match; (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
CME Rep. 4, A-05 Appended: Res. 330, A-11 Appended: Res. 920, I-11 Appended: Res. 311, A-14 Appended: Res. 312, A-14 Appended: Res. 304, A-15 Appended: CME Rep. 03, A-16 Reaffirmation: A-16 Appended: CME Rep. 06, A-17 Appended: Res. 306, A-17 Modified: Speakers Rep. 01, A-17

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-19

Subject:	Council on Medical Education Sunset Review of 2009 House Policies
Presented by:	Carol Berkowitz, MD, Chair
Referred to:	Reference Committee C (Nicole Riddle, MD, Chair)

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations. The current policy reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the 2009 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS ON 2009 AND OTHER RELATED HOUSE OF DELEGATES POLICIES

Policy Number, Title, Policy	**Recommended Action**
H-30.983, "Medical Education on Alcoholism and Other Chemical Dependencies"	
The AMA supports (1) taking a leadership role in educating or causing changes in physician education for exposure to early identification, treatment and prevention of alcoholism and other chemical dependencies; and (2) public education efforts in coordination with other interested groups on an ongoing basis. (Res. 67, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.
H-200.957, "Proper Notification and Education Regarding Healthcare Professional Shortage Areas by Medicare Carrier"	
Our AMA shall educate member physicians regarding Medicare Part B carriers' responsibility to notify all physicians that if they practice in a Healthcare Professional Shortage Area, they are eligible for incentive payments under Centers for Medicare & Medicaid Services guidelines, and they may be eligible to file amended claims under the incentive payment program retroactively for up to twelve months. (Res. 103, I-99; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.
D-200.998, "Physician Workforce Planning and Physician Re-Training"	
Our AMA will consider physician retraining during all its deliberations on physician workforce planning. (Res. 324, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Retain through incorporation into H-200.955, "Revisions to AMA Policy on the Physician Workforce," as follows: (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.
D-225.999, "The Emerging Use of Hospitalists: Implications for Medical Education"	
(1) Our AMA, through its Council on Medical Education and Council on Medical Service, will collect data on the following areas: (a) the emergence of educational opportunities for hospitalist physicians at the residency level, including the curriculum of hospitalist tracks within residency training programs; (b) the availability and content of continuing medical education opportunities for hospitalist physicians; (c) the policies of hospitals and	Sunset; directive has been accomplished through reports from both Councils.

managed care organizations related to the maintenance of hospital privileges for generalist physicians who do not typically care for inpatients; and (d) the quality and costs of care associated with hospitalist practice. (2) Our Council on Medical Education and Council on Medical Service will monitor the evolution of hospitalist programs, with the goal of identifying successful models. (3) Our AMA will encourage dissemination of information about the education implications of the emergence of hospitalism to medical students, resident physicians, and practicing physicians. (CME Rep. 2, A-99; Reaffirmed: CME Rep. 2, A-09)	

H-230.959, "Ultrasound and Biopsy of the Thyroid"

Our AMA adopts the position that only appropriately trained and credentialed physicians (M.D. and D.O.) and appropriately trained and certified ultrasound technologists perform ultrasound examinations of the thyroid and that only appropriately trained and credentialed physicians evaluate and interpret ultrasound examinations and perform ultrasound-guided biopsies of the thyroid. (Sub. Res. 818, I-99; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

H-230.989, "Patient Protection and Clinical Privileges"

Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose; (3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. However, the same standards of performance should be applied to limited practitioners who	Retain; still relevant.

offer the kinds of services that can be performed by limited licensed health care practitioners or physicians; and (4) health care facilities that grant privileges to limited licensed practitioners should provide that patients admitted by limited licensed practitioners undergo a prompt medical evaluation by a qualified physician; that patients admitted for inpatient care have a history taken and a comprehensive physical examination performed by a physician who has such privileges; and that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff. (Sub. Res. 36, A-84; Reaffirmed: CME Rep.8, I-93; Reaffirmed: Res. 802, I-99; Reaffirmed: CME Rep. 2, A-09)	

H-255.974, "Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US"

In the event of reductions in the resident workforce, the AMA will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions; and the AMA adopts the position that it will be an advocate for IMGs already legally present in this country. (Res. 324, A-97; Reaffirmed: CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by other policies on IMGs, including H-255.988, "AMA Principles on International Medical Graduates" and D-255.982, "Oppose Discrimination in Residency Selection Based on International Medical Graduate Status." Through the work of its IMG Section and related initiatives, the AMA is a preeminent advocate for IMGs.

D-275.963, "Ensuring Diversity in United States Medical Licensing Examination Exams"

Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers. (Sub. Res. 306, A-09)	Retain; still relevant.

D-295.319, "Discriminatory Questions on Applications for Medical Licensure"

Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate	Sunset; superseded by H-275.970, "Licensure Confidentiality," which reads: "1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards,

diagnosis and treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health. (Res. 925, I-09)	to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. "2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

D-295.325, "Remediation Programs for Physicians"

1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level. 2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of	Retain; still relevant.

physician remediation programs, especially the relationship between program outcomes and the quality of patient care. 3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians. 4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills. 5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians. (CME Rep. 3, A-09)	

D-295.326, "Recognition of Osteopathic Education and Training"

Our AMA will explore the feasibility of collaborating with other stakeholder organizations and funding agencies to convene leaders in allopathic and osteopathic medicine responsible for undergraduate and graduate medical education, accreditation and certification, to explore opportunities to align educational policies and practices. (CME Rep. 12, A-09)	Sunset; this is being accomplished at the graduate medical education level through the Single GME Accreditation System.

D-295.328, "Promoting Physician Lifelong Learning"

1. Our AMA encourages medical schools and residency programs to explicitly include training in and an evaluation of the following basic skills: (a) the acquisition and appropriate utilization of information in a time-effective manner in the context of the care of actual or simulated patients; (b) the identification of information that is evidence-based, including such things as data quality, appropriate data analysis, and analysis of bias of any kind; (c) the ability to assess one's own learning needs and to create an appropriate learning plan;	Retain; still relevant.

(d) the principles and processes of assessment of practice performance; (e) the ability to engage in reflective practice. 2. Our AMA will work to ensure that faculty members are prepared to teach and to demonstrate the skills of lifelong learning. 3. Our AMA encourages accrediting bodies for undergraduate and graduate medical education to evaluate the performance of educational programs in preparing learners in the skills of lifelong learning. 4. Our AMA will monitor the utilization and evolution of the new methods of continuing physician professional development, such as performance improvement and internet point-of-care learning, and work to ensure that the methods are used in ways that are educationally valid and verifiable. 5. Our AMA will continue to study how to make participation in continuing education more efficient and less costly for physicians. (CME Rep. 10, A-09)	

D-295.329, "Communication and Clinical Teaching Curricula"

Our AMA will: 1. encourage the Liaison Committee on Medical Education to continue to enforce accreditation standards requiring that faculty members and resident physicians are prepared for and evaluated on their teaching effectiveness; 2. encourage the Accreditation Council for Graduate Medical Education to create institutional-level standards related to assuring the quality of faculty teaching; 3. encourage medical schools and institutions sponsoring graduate medical education programs to offer faculty development for faculty and resident physicians in time-efficient modalities, such as online programs, and/or to support faculty and resident participation in off-site programs; 4. encourage medical educators to develop and utilize valid and reliable measures for teaching effectiveness; and 5. encourage medical schools to recognize participation in faculty development for purposes of faculty retention and promotion. (CME Rep. 9, A-09)	Retain; still relevant.

D-295.330, "Update on the Uses of Simulation in Medical Education"

Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs; 3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum. (CME Rep. 8, A-09)	Retain; still relevant.

H-295.867, "Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year"

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. 2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by	Retain; still relevant.

COCA and teaching institutions not affiliated with a medical school. 3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students. (Res. 910, I-09)	

H-295.887, "Clinical Skills Assessment During Medical School"

Our AMA encourages medical schools that do not already do so to implement valid and reliable methods to evaluate medical students' clinical skills. (CMS Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by D-295.988, "Clinical Skills Assessment During Medical School," which reads in part: "1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should 'develop a system of assessment' to assure that students have acquired and can demonstrate core clinical skills… "3. Our AMA will work to … include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. "4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. "5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed."

H-295.889, "Color Blindness"

Our AMA will encourage medical schools to be aware of students with color blindness and its effect on their medical studies. (Sub. Res, 303, A-99; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

H-295.890, "Medical Education and Training in Women's Health"

Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women's health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served; (4) that surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training; (5) encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs; (6) encourages physicians to include continuing education in women's health/gender based biology as part of their continuing professional development; and (7) encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the various Residency Review Committees to promote attention to women's health in accreditation standards. (Jt. Rep. CME and CSA, A-99; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

H-295.919, "Advanced Cardiac Life Support Training"

Our AMA: (1) strongly supports the teaching of advanced cardiac life support and basic life support beginning in medical school and continuing during residency training; and (2) encourages medical schools to include the following areas related to airway management as part of the required curriculum: (a) airway anatomy and function; (b) basic life support and advanced cardiac life support, and (c) airway management and intubation in the unconscious patient. (Sub. Res. 309, A-95; Reaffirmed and Appended: CME Rep. 3, I-99; Reaffirmed and Modified: CME Rep. 2, A-09)	Sunset; this has become well established in medical education and practice.

H-295.949, "Encouraging Community Based Medical Education"

Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching. (Res. 44, A-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 9, A-09)	Retain through incorporation into H-295.916, "Improving Medical School/Community Practice," as follows: 1. Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching. ~~1~~2. Medical schools should be encouraged to include community physicians who serve as volunteer faculty in medical school activities and in committees and other decision-making bodies related to the student educational program, such as the curriculum committee and the admission committee, and in search committees for medical school deans and department chairs. ~~2~~3. County/state medical societies should be encouraged to include medical school administrators and faculty members in committees and other society activities, and to consider creating a seat for medical school deans in the state society house of delegates. ~~3~~4. There should be mechanisms established at local or state levels to address tensions arising between the academic and practice communities, such as problems associated with the granting of faculty appointment or hospital staff privileges.

	4<u>5</u>. Medical schools and other academic continuing medical education providers should work with community physicians to develop continuing education programs that address local needs. <s>5</s><u>6</u>. Community physician groups and schools of medicine should be encouraged to communicate during the initial stages of discussions about the formation of patient care networks.

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 fostering the development of professionalism. (CME Rep. 3, A-01; Reaffirmation I-09)	Retain; still relevant, with editorial change as shown below: (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<s>?</s><u>'</u> acquisition of professionalism.

D-295.992, "Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socioeconomic Aspects of Practice and Physician Advocacy"

Our AMA will assist local and state medical societies to develop education programs on the political, legal, and socioeconomic aspects of medical practice and physician advocacy, to be offered to medical students and physicians in residency training throughout the country to supplement their clinical education and prepare them for practice. (Res. 322, A-99; Reaffirmed: CME Rep. 2, A-09	Sunset; superseded by the following policies, as excerpted below. H-295.961, "Medicolegal, Political, Ethical and Economic Medical School Course" "The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses..." H-295.953, "Medical Student, Resident and Fellow Legislative Awareness" "1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students. "2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum. "3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows. "4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows." H-295.977, "Socioeconomic Education for Medical Students" "1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or

	maintain material on health care economics in medical school curricula. "2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9." H-295.924, "Future Directions for Socioeconomic Education" "The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."

D-295.996, "Update on Development of Branch Campuses of International Medical Schools"

Our AMA will join with the Association of American Medical Colleges in continuing to support the process of voluntary accreditation of medical education programs. (BOT Rep. 25, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Retain, still relevant.

D-300.981, "Proposed Fee Increase by the Accreditation Council for Continuing Medical Education"

Our AMA will strongly urge the Accreditation Council for Continuing Medical Education (ACCME) to reconsider the proposed fee increase and, if the ACCME refuses to reconsider the proposed fee increase, our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. (Res. 312, A-09)	Retain, still relevant; also, will be covered in more detail in a planned Council on Medical Education report.

D-305.963, "Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency"

Our AMA will: 1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. 2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. 3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. 4. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies. (CME Rep. 4, I-08 Reaffirmed: CME Rep. 3, I-09 Modified: CCB/CLRPD Rep. 2, A-14)	Sunset; already accomplished, or superseded by other AMA policy. Items 1 and 2 have been addressed: For direct graduate medical education funds, CMS will count research time if it's part of the ACGME-accredited program; for indirect GME, CMS will count research time if it's associated with the treatment or diagnosis of a particular patient. The brochure "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know," from the Association of American Medical Colleges," provides additional information on this topic: "16. What about the time I spend doing research? "For DGME payments, a hospital may count the time a resident spends performing research, including bench research, as long as the research takes place in the hospital and is part of an approved training program. For IME payments, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient. If you were to take a year away from your residency training specifically to conduct research not required by your residency program, the research year would not count toward your IRP. For example, if you had completed three years of a general surgery program (a program with a five-year IRP), and you stepped away from the program for one year to do research not

	required by your program, you would still have two years remaining on your IRP when you returned to training after your research year." Item 3 is superseded by more comprehensive AMA policy, including D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and H-310.917, "Securing Funding for Graduate Medical Education." Item 4 is superseded by H-460.930, "Importance of Clinical Research," which reads in part: "(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense."

D-305.996, "Coding for Services Involving Teaching Activity"

Our AMA will continue its efforts to develop the next generation of CPT coding, with attention to the coding needs of teaching physicians. (BOT Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Retain; still relevant.

D-305.997, "Training of Physicians Under Managed Care"

Our AMA will monitor ongoing legislative initiatives and support specific language that would preserve the opportunities for medical students and resident physicians to participate in the care of patients under the supervision of the responsible attending staff. (CME Rep. 4, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Sunset; superseded by H-295.995, "Recommendations for Future Directions for Medical Education," which reads in part: "(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education." Also superseded by H-285.974, "Residents Working with Managed Care Programs," which reads: "The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting."

H-310.930, "Attending Physician Supervision of Night-Float Rotations"

Our AMA supports hospitals and residency programs including those utilizing a night-float system, continuing to assure that there is rapid access to appropriately qualified attending physicians for trainee supervision and the provision of the best quality of patient care. (Res. 320, A-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by the following policies: H-310.929, "Principles for Graduate Medical Education" "(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The

	attending physician, or designate, must be available to the resident for consultation at all times." H-310.907, "Resident/Fellow Clinical and Educational Work Hours" "6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: … develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home." "o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations." In addition, the following from the AMA *Code of Medical Ethics* is relevant to rescission of this policy: Opinion 9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care" "Physicians involved in training residents and fellows should … (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise."

H-310.945, "Graduate Medical Education Faculty Evaluations"

The AMA recommends that evaluations of residency program faculty should be done in a confidential manner, at least annually, and the areas evaluated should include teaching ability, clinical knowledge, scholarly contributions, attitudes, interpersonal skills, communication ability and commitment. Residency program directors should provide faculty members with a written summary of the evaluations. (CME Rep. 7, I-93; Reaffirmed and Modified: CME Rep. 2, A-05; Reaffirmed: CME Rep. 9, A-09)	Retain; still relevant.

D-310.956, "Transfer of Care for Resident and Fellow Physicians in Training"

Our AMA: (1) working with other organizations and stakeholders, will identify best practices including the presence, quality, and utilization of computerized systems for transfer of care in training programs in all specialties; (2) will encourage the ACGME to add to the Institutional Requirements a requirement that GME training institutions ensure that trainees in all specialties are provided with an effective, systematic approach for handoffs of clinical information and transfer of care between trainees within their institution; and (3) will advocate for the use of federal dollars in existing Health Information Technology (HIT) initiatives to sponsor systems that enable transfers of care that are integral to any well-functioning electronic medical record. (Res. 329, A-09)	Sunset, for reasons stipulated below. Item 1 is superseded by H-310.907, "Resident/Fellow Clinical and Educational Work Hours," which reads in part: "3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs..." Item 2 is already reflected in ACGME Institutional Requirements (effective July 1, 2018): *III.B.3. Transitions of Care: The Sponsoring Institution must:* *III.B.3.a) facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, (Core)* *III.B.3.b) in partnership with its ACGME-accredited program(s), ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites. (Core)* Item 3 has been accomplished. HITECH (Health Information Technology for Economic and Clinical Health) Act funding for health information exchanges (HIEs) has run out, the Meaningful Use program is over, and the AMA successfully advocated to the Centers for Medicare & Medicaid Services (CMS) to focus its Performance Improvement efforts on interoperability. In fact, the newest HIE measures from CMS are on closing the referral loop—a core function in care transfer. Finally, the AMA has a significant number of other policies on broader advocacy efforts for interoperability.

D-310.957, "Resident and Fellow Benefit Equity During Research Assignments"

1. Our AMA will urge the Accreditation Council for Graduate Medical Education to require accredited sponsoring residency and fellowship training programs to continue to provide comparable benefits to resident and fellow physicians engaged in research activities that are required by either their sponsoring residency and fellowship training programs or residency review committees as if it were full-time clinical service. 2. Our AMA will collect data on resident and fellow physician benefits including resident and fellow physicians engaged in research activities. 3. Our AMA will, through the AMA Resident and Fellow Section, continue to work with residents and fellows and support training of biomedical scientists and health care researchers. 4. Our AMA will advocate that the Centers for Medicare & Medicaid Services include in an expanded cap the FEC count for GME payment formulas the time that resident and fellow physicians spend in research and other scholarly activities that is required by the ACGME. (CME Rep. 14, A-09)	Sunset, as described below. Item 1 would be anticompetitive, and unenforceable, based on an analogous ACGME requirement from the 1990s, which stated that all clinical residents at the same level be paid the same amount. This 1990s requirement was ruled anticompetitive by the U.S. Department of Justice at that time; item 1 would in all likelihood meet with the same decision. Despite research by AMA staff, it is unclear whether item 2 was accomplished; that said, it does not seem likely that it can be (or would be) accomplished in the future. Item 3 is *a priori* the role of the Resident and Fellow Section. Item 4 has been addressed: For direct graduate medical education funds, CMS will count research time if it's part of the ACGME-accredited program; for indirect GME, CMS will count research time if it's associated with the treatment or diagnosis of a particular patient. The brochure "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know," from the Association of American Medical Colleges, provides additional information on this topic: "16. What about the time I spend doing research? "For DGME payments, a hospital may count the time a resident spends performing research, including bench research, as long as the research takes place in the hospital and is part of an approved training program. For IME payments, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient. If you were to take a year away from your residency training specifically to conduct research not required by your residency program, the research year would not count toward your IRP. For example, if you had completed three years of a general surgery program (a program with a

	five-year IRP), and you stepped away from the program for one year to do research not required by your program, you would still have two years remaining on your IRP when you returned to training after your research year."

D-310.960, "Timely Issuance of Social Security Number"

Our AMA will work with the United States government to provide a social security number in a timely fashion to foreign physicians with a work-related visa, upon lawful entry to the United States, for any purposes. (Res. 304, A-09)	Retain; still relevant.

H-350.968, "Medical School Faculty Diversity"

Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools. (CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce," which reads in part (relevant portions in italics): "1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and *d. Financial support programs to recruit and develop faculty members from underrepresented groups."* *"4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty."*

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-19)
Update on Maintenance of Certification and Osteopathic Continuous Certification
(Resolution 316-A-18)
(Reference Committee C)

EXECUTIVE SUMMARY

The Council on Medical Education has monitored Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) during the last year. This annual report, mandated by American Medical Association (AMA) Policy D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification," provides an update on some of the changes that have occurred as a result of AMA efforts with the American Board of Medical Specialties (ABMS), ABMS member boards, and key stakeholders to improve the continuing board certification process.

In December 2018, the Council provided comments to strengthen the draft recommendations of the Continuing Board Certification: Vision for the Future Commission, established by the ABMS. In February 2019, the Commission completed its final report, which includes 14 recommendations intended to modernize continuing board certification so that it is meaningful, contemporary, and a relevant professional development activity for diplomates who are striving to be up-to-date in their specialty. The ABMS and ABMS member boards, in collaboration with professional organizations and other stakeholders, will prioritize these recommendations and develop the strategies and infrastructure to implement them. A summary of the recommendations is provided in this report.

This report also highlights initiatives that are underway to improve MOC:

- Twenty-three ABMS member boards have moved away from the secure, high-stakes exam, and more than three-fourths of the boards have completed, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art technology, enabling delivery of assessments that are a more relevant, less onerous, and cost-efficient process for physicians. Appendix F in this report summarizes these new models.
- The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements. Appendix F includes a summary of these initiatives.
- New studies published during the last year describe how new assessment models and IMP activities have resulted in improved quality and patient care and physician satisfaction.

Updates on the following activities are also included in this report:

- AMA participation in meetings and conferences to improve the MOC process (pages 4-5)
- New innovative continuing medical education models (pages 5-6)
- Alternatives to the secure, high-stakes examination (Part III) (pages 6-7)
- Improvement in medical practice (Part IV) (pages 7-8)
- The ABMS Multi-Specialty Portfolio Program (page 8)
- Emerging data and literature regarding the value of MOC (pages 8-12)
- Osteopathic Continuous Certification (pages 12-13)

The Council on Medical Education is committed to ensuring that continuing board certification supports physicians' ongoing learning and practice improvement and can assure the public that physicians are providing high-quality patient care. The Council will continue to identify and suggest improvements to continuing certification programs.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-19

Subject:	Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 316-A-18)
Presented by:	Carol Berkowitz, MD, Chair
Referred to:	Reference Committee C (Nicole Riddle, MD, Chair)

Resolution 316-A-18, "End Part IV IMP Requirement for ABMS," introduced by Michigan and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to call for an end to the mandatory American Board of Medical Specialties "Part 4 Improvement in Medical Practice" maintenance of certification requirement.

Policy D-275.954 (39), "Maintenance of Certification and Osteopathic Continuous Certification," asks the AMA to continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education's annual report on maintenance of certification at A-19.

Policy D-275.954 (1), "Maintenance of Certification and Osteopathic Continuous Certification," asks that the AMA continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the HOD regarding the MOC and OCC processes.

BACKGROUND

During the 2018 Annual Meeting, testimony before Reference Committee C was mixed regarding Resolution 316-A-18. Testimony noted the lack of relevance, burden, and cost of the Maintenance of Certification (MOC) Part IV process in addition to the other requirements physicians are required to fulfill for meaningful use, the Medicare Access and CHIP Reauthorization Act (MACRA), etc. However, it was also noted that the broadening range of acceptable activities that meet the Improvement in Medical Practice (MOC Part IV) component has made this activity acceptable for other national value-based reporting requirements and continuing certification programs. It was further noted that the boards are implementing a number of activities related to registries, systems-based practice, and practice audits to show improvement in practice. The ABMS Multi-Specialty Portfolio Program™ offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the Improvement in Medical Practice component of the ABMS Program for MOC. Due to the Council on Medical Education's ongoing work with the ABMS and the ABMS member boards to improve this process, the HOD referred this item for further study as part of this annual report.

CONTINUING BOARD CERTIFICATION: VISION FOR THE FUTURE COMMISSION

In early 2018, the Continuing Board Certification: Vision for the Future Commission was established by the ABMS and charged with reviewing continuing certification within the current context of the medical profession. The Commission was also asked to address key issues currently facing the ABMS member boards and diplomates. The Commission was composed of 27 individuals who represented diverse stakeholders including practicing physicians; health care leadership; academic medicine; group medical practices; state and national medical associations; ABMS Board executives; specialty societies; and health advocate groups who represented patients, families, and the public at large.

In March 2018, shortly after the Commission was established, the Council on Medical Education co-convened a conference with the ABMS, ABMS member boards, and key stakeholders to discuss how continuing board certification can meet the needs of diverse stakeholders, including physicians, hospitals, patients, and the public, and to develop recommendations for the Commission. Meeting attendees explored approaches for maximizing assessment, learning, and improvement. The meeting also highlighted the importance of addressing physicians' needs and expectations while at the same time recognizing the value of continuous maintenance and improvement of competence. While no effort was made to develop consensus on any specific issue, the discussion reflected a broad range of attitudes and opinions, and nine emergent themes about continuing certification were identified that suggested the process should be affirmative, affordable, aligned, appropriately managed, collaborative, innovative, meaningful, patient-focused, and supportive.

Throughout 2018, the Commission conducted a national survey, heard public testimony from diplomates and key stakeholders, and held Commission meetings to review the information collected and presented. The Commission used this knowledge base to establish a conceptual framework and guiding principles that were then used to draft its report and recommendations. The recommendations highlighted the need for any assessment framework to identify gaps in knowledge and skills that are relevant to the physician's practice in order to foster lifelong learning and assist physicians in remaining current with new knowledge and advances in medicine. In its recommendations, the Commission emphasized that improving practice and quality of care is an important goal of the continuing certification process, which means assessing practice data and gaps in quality of care. The Commission recommended new program models for continuing board certification that are responsive to the needs of those who rely on the system, and that are relevant, meaningful, and of value to those who hold the credential. A number of recommendations relate to the process of creating a better system of continuing certification and to the ways that continuing certification status is used by health systems and payers. The Commission stressed the importance of collaboration with professional organizations in the redesign of MOC and noted that any framework for continuing certification must be assessed by independent research to integrate continuous quality improvement (QI) into the continuing board certification process. The Commission's draft report and recommendations were widely circulated for comments.

In December 2018, the Council on Medical Education reviewed the Commission's draft report and recommendations and provided comments back to the Commission. The Council praised the Commission for producing a thorough report and for acknowledging long-standing physician frustrations, such as the concern that the benefits of the continuing certification process traditionally have not been worth the time or financial investment required for participation. At the same time, however, the Council strongly objected to some of the draft recommendations and other portions of the report (Appendix A).

On February 12, 2019, the Commission released its final report, which included a total of 14 recommendations (https://visioninitiative.org/commission/final-report/). Of these, the Commission emphasized that some must be implemented by the ABMS and its member boards in the short term (one to two years) or within an intermediate time frame (e.g., less than five years). The Commission also noted that one recommendation is foundational and three are aspirational.

Most of the Council's concerns were addressed in the final report (Appendix B). For example, the final recommendations included stronger language regarding the secure, high-stakes examination and the acceptance of quality data already being reported by individual physicians. The final recommendations also note that the ABMS must demonstrate the value, meaning, and purpose of continuing certification, but that it should not be the only criterion used for credentialing and privileging decisions. In addition, detailed financial transparency regarding fiscal responsibility toward diplomates was addressed. As suggested by the Council, the final recommendations also emphasize the need for a more consistent process and requirements for continuing certification among the ABMS member boards.

On March 12, 2019, after reviewing the final recommendations of the Commission, the ABMS Board of Directors announced that all 24 member boards had accepted the Commission's recommendations. To support implementation, the ABMS Board of Directors also announced the establishment of the Achieving the Vision for Continuing Board Certification Oversight Committee (https://www.abms.org/media/194984/abms-announces-plan-to-implement-recommendations-from-the-continuing-board-certification-vision-for-the-future-commission.pdf). This committee will seek guidance from the ABMS' new Stakeholder Council and various stakeholders in the continuing certification process throughout the implementation phase. Possible implementation actions include: considering how the standards for continuing certification should be revised to reflect a more integrated framework, additional flexible approaches to knowledge assessment, feedback requirements from boards to diplomates, consistency in requirements and core processes, defining categories of consequential decisions, pathways for lifetime certificate holders to engage with continuing certification, consistency regarding professional standing, and providing a "wide door" for QI/performance improvement activities that satisfy continuing certification requirements. Organizational standards such as governance composition and financial transparency will also be reviewed.

The ABMS has attained the agreement of all member boards to commit to longitudinal or other formative assessment strategies and to offer alternatives to the highly secure, point-in-time examinations of knowledge. Other implementation actions may include developing and defining best practices for diplomate engagement; developing policies regarding diplomates with multiple certificates; allocating funds and/or allowing access to data to support external research; displaying diplomate participation on public websites; and communicating and educating hospitals, health systems, payers, and other health care organizations about the appropriate use of the continuing board certification certificate. The ABMS will involve external stakeholders and form additional task forces to address remediation pathways, assessment of professionalism, QI and advancing practice, and data and information sharing. A meeting of the ABMS/Council of Medical Specialty Societies joint board leadership will also be established to ensure full specialty society engagement in building the road map defined by the Commission report, especially with regard to the role of continuing certification in advancing clinical practice.

The Commission's final recommendations align with HOD policies and directives (Appendix C). Thus, it will be important for the Council on Medical Education to continue to work with the ABMS, ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to

pursue opportunities to implement the Commission's recommendations and to ensure that the continuing certification process is meaningful and relevant for physicians and patients.

MAINTENANCE OF CERTIFICATION (MOC): AN UPDATE

The AMA Council on Medical Education and the HOD have carried out extensive and sustained work in developing policy on MOC and OCC (Appendix D), including working with the ABMS and the AOA to provide physician feedback to improve the MOC and OCC processes, informing our members about progress on MOC and OCC through annual reports to the HOD, and developing strategies to address the concerns about the MOC and OCC processes raised by physicians. The Council has prepared reports covering MOC and OCC for the past ten years.[1-10] During the last year, Council members, AMA trustees, and AMA staff have participated in the following meetings with the ABMS and its member boards:

- ABMS Committee on Continuing Certification
- ABMS Forum on Organizational Quality Improvement
- ABMS 2018 Conference
- Maintenance of Certification Summit
- ABMS Board of Directors Meeting
- AMA Council on Medical Education/ABMS/ABMS member boards joint meeting to explore approaches for maximizing assessment, learning, and improvement

ABMS Committee on Continuing Certification to Refocus the Direction of MOC

The ABMS Committee on Continuing Certification (3C) is charged with reviewing existing MOC programs to ensure that the ABMS member boards meet the 2015 Standards for the Program for MOC, which evaluate the effectiveness of different approaches to MOC and identify innovations to share among the boards. During 2018, the 3C approved substantive changes that have been implemented and announced new active pilot programs (Appendix E). In April and November, the 3C also met with content experts who research physician competence and administer assessment programs to discuss the future development of continuing professional development programs as well as security considerations, performance standards, and psychometric characteristics with longitudinal assessment programs.

ABMS Stakeholder Council

In 2018, the ABMS established a new Stakeholder Council to serve as an advisory body representing the interests of volunteer physicians, patients, and the public. The Council's fundamental role is to ensure that the ABMS Board of Directors makes decisions grounded in an understanding of the perspectives, concerns, and interests of multiple constituents and stakeholders who may be impacted by the work of ABMS. The Stakeholder Council is composed of five representatives from among ABMS associate members, six public members, two at-large member board executives or directors/trustees, one member from the greater credentialing community, and ten practicing physicians.

ABMS Accountability and Resolution Committee

In 2018, the ABMS also established the Accountability and Resolution Committee (ARC). The ARC serves as a subcommittee of the ABMS Board of Directors and addresses and makes

recommendations to resolve complaints and problems related to noncompliance by the boards, both organizational and individual, that have not been resolved through other mechanisms.

Update on Membership of Young Physicians Serving on ABMS and ABMS Member Boards

The ABMS is working with its member boards to encourage early-career physicians to participate in ABMS work by promoting opportunities for engagement to young physicians, reducing travel obligations with online/remote engagement opportunities, choosing easily accessible locations for in-person meetings, and integrating opportunities for engagement into established annual meetings whenever possible.

The boards recognize that early-career physicians have demands on their time, and that committing to participation on ABMS and/or ABMS member board leadership boards or committees may not be feasible. However, it is common for early-career physicians to begin their involvement with the member boards by serving as volunteer test item writers. The ABMS and the member boards recruit and encourage early-career physicians to participate, solicit nominations from medical societies for opportunities including the newly formed Stakeholder Council, promote volunteer opportunities on diplomate dashboards and websites, and promote volunteer opportunities through social media platforms. The member boards also encourage early-career physicians to participate in focus groups and to contribute to standard setting and practice analysis groups. Further, the ABMS and some member boards have Visiting Scholars Programs that encourage early-career physicians to get involved through scholarly work in the member boards community.

Update on New Innovative Continuing Medical Education (CME) Models

The ABMS Continuing Certification Directory™ (https://www.abms.org/initiatives/abms-continuing-certification-directory/) continues to offer physicians access to a comprehensive, centralized, web-based repository of CME activities that have been approved for MOC credit by ABMS member boards. During the past year, the directory has increased its inventory and now indexes 700-plus activities from more than 60 CME providers to help diplomates from across the specialties meet MOC requirements for Lifelong Learning and Self-Assessment (Part II) and Improvement in Medical Practice (Part IV).

The following types of activities are currently included in the directory: internet enduring activities, journal CME, internet point of care, live activities, and performance improvement CME. All CME activities are qualified to award credit(s) from one or more of the CME credit systems: *AMA PRA Category 1 Credit*™, AAFP Prescribed Credit, ACOG Cognates, and AOA Category 1-A.

The member boards also employ technology to personalize assessments that promote greater self-awareness and support participation in CME. For example, the American Board of Anesthesiology (ABA) is now able to link assessment results from its MOCA Minute® program with CME opportunities. More than half (53 percent) of MOCA Minute® questions can be linked to at least one CME activity, and more than 110 accredited CME providers have been able to link a combined total of 3,261 activities to the MOCA content outline.[11]

Elimination of the Secure, High-stakes Examination for Assessing Knowledge and Cognitive Skills in MOC

Twenty-three ABMS member boards (95.8 percent) have moved away from the secure, high-stakes exam, and more than three-fourths of the boards (75 percent) have completed, or will soon be launching, assessment pilots that combine adult learning principles with state-of-the-art

technology, enabling delivery of assessments that promote learning and are less stressful (Appendix F).

Three member boards will be converting their pilot programs into permanent options in 2019. The ABA, American Board of Obstetrics and Gynecology (ABOG), and American Board of Pediatrics (ABP) will offer innovative alternatives to the traditional examinations, which may offer both time and cost savings to physicians certified by these boards by reducing or eliminating the need for study courses, travel to exam centers, and time away from practice. Overall, the programs allow physicians to assess their knowledge, fill knowledge gaps, and demonstrate their proficiency. The programs engage physicians in answering 80 to 120 questions per year; allow for the development of practice-relevant content; offer convenient access on computer, tablet, or smartphone; and provide immediate feedback and guidance to resources for further study.

Seven ABMS member boards engaged in the longitudinal assessment approach with CertLink™—the American Board of Colon and Rectal Surgery (ABCRS), American Board of Dermatology (ABD), American Board of Medical Genetics and Genomics (ABMGG), American Board of Nuclear Medicine (ABNM), American Board of Otolaryngology-Head and Neck Surgery (ABOHNS), American Board of Pathology(ABPath), and American Board of Physical Medicine and Rehabilitation (ABPMR)—have launched their pilots. CertLink™ is a technology platform developed by the ABMS to support the boards in delivering more frequent, practice-relevant, and user-friendly competence assessments to physicians (https://www.abms.org/initiatives/certlink-platform-and-pilot-programs/). The platform provides technology to enable boards to create assessments focused on practice-relevant content; offers convenient access on desktop or mobile device (depending on each board's program); provides immediate, focused feedback and guidance to resources for further study; and provides a personalized dashboard that displays participating physicians' areas of strength and weakness. To date, more than 7,000 physicians are active on CertLink. These physicians have answered 200,000-plus questions across the seven member boards and have given CertLink a 96 percent approval rating.

Several ABMS member boards are participating in a Research and Evaluation Collaborative, sponsored by the ABMS and ABMS Research and Education Foundation, to develop metrics to define the success of the pilots, facilitate research and evaluation in areas of common interest, and share findings on the longitudinal assessment pilots. The evaluations will be used to inform ABMS member boards on how longitudinal assessment for learning and improvement can be used in conjunction with other information, such as portfolios of assessment modalities, to reach summative decisions on specialty certification status.[12]

Other member board efforts to improve Part III, Assessment of Knowledge, Judgment, and Skills, include more diplomate input into exam blueprints; integrating journal article-based core questions into assessments; modularization of exam content that allows for tailoring of assessments to reflect physicians' actual areas of practice; access during the exam to resources similar to those used at the point of care; remote proctoring to permit diplomates to be assessed at home or in the office; and performance feedback mechanisms. All boards also provide multiple opportunities for physicians to retake the Part III exam. These program enhancements will significantly reduce the cost diplomates incur to participate in MOC by reducing the need to take time off or travel to a testing center for the assessment; ensure that the assessment is practice-relevant; emphasize the role of assessment for learning; assure opportunities for remediation of knowledge gaps; and reduce the stress associated with a high-stakes test environment.

Progress with Improving MOC Part IV, Improvement in Medical Practice

The ABMS member boards have broadened the range of acceptable activities that meet the Improvement in Medical Practice (IMP) requirements, including those offered at the physician's institution and/or individual practices, to address physician concerns about the relevance, cost, and burden associated with fulfilling the IMP requirements (Appendix F). In addition to improving alignment between national value-based reporting requirements and continuing certification programs, the boards are implementing a number of activities related to registries, practice audits, and systems-based practice.

Patient registries (also known as clinical data registries) provide information to help physicians improve the quality and safety of patient care—for example, by comparing the effectiveness of different treatments for the same disease. While many member boards allow physicians to earn Part IV credit for participating in externally developed patient registries, the American Board of Ophthalmology (ABO), ABOHNS, and American Board of Family Medicine (ABFM) have designed performance improvement initiatives that are supported by registry data.

Several ABMS member boards have developed online practice assessment protocols that allow physicians to assess patient care using evidence-based quality indicators. Other initiatives include:

- Free tools to complete an IMP project, including a simplified and flexible template to document small improvements, educational videos, infographics, and enhanced web pages;
- Partnerships with specialty societies to design quality and performance improvement activities for diplomates with a population-based clinical focus;
- Successful integration of patient experience and peer review into several of the boards' IMP requirements (for example, one board has aggressively addressed the issue of cost and unnecessary procedures with an audit and feedback program);
- Integration of simulation options; and
- A process for individual physicians to develop their own improvement exercises that address an issue of personal importance, using data from their own practices, built around the basic Plan-Do-Study-Act (PDSA) process.

The ABMS member boards are aligning MOC activities with other organizations' QI efforts to reduce redundancy and physician burden while promoting meaningful participation. Nineteen of the boards encourage participation in organizational QI initiatives through the ABMS Multi-Specialty Portfolio Program™ (described below). Many boards encourage involvement in the development and implementation of safety systems or the investigation and resolution of organizational quality and safety problems. For physicians serving in research or executive roles, some boards have begun to give IMP credit for having manuscripts published, writing peer-reviewed reports, giving presentations, and serving in institutional roles that focus on QI (provided that an explicit PDSA process is used). Physicians who participate in QI projects resulting from morbidity and mortality conferences and laboratory accreditation processes resulting in the identification and resolution of quality and safety issues can also receive IMP credit from some boards.

ABMS Multi-Specialty Portfolio Program™

The ABMS Multi-Specialty Portfolio Program (Portfolio Program™) offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the IMP component of the ABMS Program for MOC (mocportfolioprogram.org). Originally designed as a service for large hospitals, the Portfolio

Program™ is extending its reach to physicians whose practices are not primarily in institutions. This includes non-hospital organizations such as academic medical centers, integrated delivery systems, interstate collaboratives, specialty societies, and state medical societies. Recent additions among the nearly 100 current sponsors include the American Society of Anesthesiologists, Minnesota Hospital Association, Hospital Quality Institute of the California Hospital Association, and Columbus Medical Association.

More than 3,100 types of QI projects have been approved by the Portfolio Program™, in which 19 ABMS member boards participate, focusing on such areas as advanced care planning, cancer screening, cardiovascular disease prevention, depression screening and treatment, provision of immunizations, obesity counseling, patient-physician communication, transitions of care, and patient-safety related topics including sepsis and central line infection reduction. Many of these projects have had a profound impact on patient care and outcomes. For example, during the past two years, Portfolio Program™ initiatives at the Children's Hospital of Philadelphia have been responsible for decreasing inpatient hospital days for oncology patients with fever and neutropenia by more than 35 percent, preventable readmissions for neurology patients by approximately 80 percent, and rates of urinary catheterization for febrile infants by 65 percent. Additionally, rates of pneumococcal immunization among patients with chronic kidney disease have increased by 79 percent, and the application of evidence-based practices to evaluate and manage children with attention deficit disorder and hyperactivity has increased by 50 percent. There have been nearly 26,000 instances of physicians receiving MOC IMP credit through participation in the program.

Update on the Emerging Data and Literature Regarding the Value of Continuing Board Certification

The Council on Medical Education has continued to review published literature and emerging data as part of its ongoing efforts to critically review continuing board certification issues. Although physicians still report some frustrations with the ABMS MOC process,[13-15] many improvements have been made to the MOC program, making participation more relevant, efficient, convenient, and cost-effective as well as less burdensome. The member boards are utilizing a variety of ways to incorporate important quality and patient safety activities in their continuing certification programs.[16] In addition, important peer-reviewed studies published during the last year demonstrate the benefits of participating in a continuous certification program. These studies are summarized below.

<u>Association between Continuous Certification and Practice-related Outcomes</u>

- A study that evaluated a QI intervention that trained providers on human papillomavirus (HPV) vaccination recommendations and communication methods showed that a learning collaborative model provides an effective forum for practices to improve HPV vaccine delivery. This QI intervention reduced missed opportunities for HPV vaccination in 33 community practices and 14 pediatric continuity clinics over nine months. This QI effort offered ABP MOC Part IV credit, as well as ABFM MOC Part IV credit, as incentives for participation.[17]
- A QI effort utilizing an injury prevention screening tool at pediatric offices to facilitate discussions and rescreenings with families at subsequent practitioner visits resulted in substantially improved practitioner-patient communications and more families reporting safer behaviors at later visits. Physicians who participated and submitted data for the QI effort received ABP MOC Part IV credit.[18]
- A QI effort to evaluate how a distance-learning, QI intervention to improve pediatric primary care physicians' use of attention-deficit/hyperactivity disorder parent and teacher rating scales

showed that the level of engagement in this QI effort was an important consideration. The results of the study, involving 105 clinicians at 19 sites, showed that those who participated in at least one feedback call, and those who participated in MOC, had higher rates of sending parent rating scales.[19]

- A study to determine the impact of a multi-component QI intervention on Chlamydia screening rates for young women showed that this practice-based QI intervention resulted in a 21 percent increase in annual Chlamydia screening rates among adolescent females without lengthening median visit time. This effort offered ABP MOC Part IV credit as an incentive for participation.[20]
- A study that assessed whether participation by Georgia pediatricians in the Healthy Weight Counseling MOC program was associated with greater use of weight management strategies showed that such participation was indeed associated with increased use of health messages and behavior change goal-setting. Importantly, weight-related counseling practices were sustained six months after the program ended.[21]
- A QI effort to review an electronic medical records tool called My Personal Outcomes Data (MyPOD) that tracked surgical outcomes at the Nemours-AI duPont Hospital for Children compared MyPOD and the National Surgical Quality Improvement Program (NSQIP) databases. The NSQIP program and similar EMR-driven tools are becoming essential components of the American Board of Surgery (ABS) MOC process. The study showed how problems that can occur with self-reporting can be addressed through the MOC Part IV process.[22]
- A study to determine if a decrease in CT scans for emergency department patients with a chief complaint of headache was followed by an increase in missed diagnoses or an increase in mortality rates showed that out of 582 patients, there were 10 missed diagnoses and 9 deaths, but no difference in mortality rate, after a reduction in CT scans. The authors concluded that these results show that the use of CT scans may be safely reduced for emergency department patients. The study fulfilled the American Board of Emergency Medicine (ABEM) MOC QI requirement, which required collecting data before and after the intervention.[23]
- In a study presenting the results of a survey of 112 radiology departments across the United States regarding quality indicators, MOC participation was found to be varied and a requirement of employment for nearly half of the respondents. The authors note that MOC is currently the best measure of a radiologist staying current with recommended practices.[24]
- A study to examine the practice behavior of emergency medicine physicians when caring for patients with chest pain showed that resident emergency physicians were more likely to hospitalize patients and board-certified physicians were more likely to discharge patients, which the study attributes to possible levels of clinical experience among these physicians and a concern that an acute coronary syndrome (ACS) diagnosis could be missed. The authors conclude that the overestimation of ACS without risk assessment was prevalent among emergency resident physicians.[25]
- A study conducted to determine if the imposition of American Board of Internal Medicine (ABIM) MOC completion requirements affected adherence to guideline-compliant mammography screening for Medicare beneficiaries showed that the MOC requirement was associated with an increase in annual screening and biennial screening, leading to improved guideline-compliant mammography screening.[26]
- A study to assess associations between MOC and performance on Healthcare Effectiveness Data and Information Set (HEDIS) process measures showed that maintaining certification was positively associated with performance scores on these process measures.[27]
- Price et al. evaluated 39 studies to examine the relationship of MOC to physician knowledge, clinical practice processes, or patient care outcomes. The studies in this analysis offered examples of how continuing certification can work or how it is currently working and showed

positive associations between participation in MOC program activities and physician and patient outcomes.[28]

- A literature review by Holloway examined evidence for improved HPV vaccination rates from 46 studies. The studies show that using a multi-method approach—such as a MOC PI CME intervention that combines repeated contacts, education, individualized feedback, and strong quality improvement incentives to increase both initiation and completing dosing of the HPV vaccine series among male and female adolescents—will increase vaccination rates.[29-30]

Standardized Simulation-based Assessment, Performance Gaps, and Opportunities for Improvement

- A study to determine whether mannequin-based simulation can reliably characterize how board-certified anesthesiologists manage simulated medical emergencies showed that standardized simulation-based assessment identified performance gaps and informed opportunities for improvement. The study involved 263 consenting board-certified anesthesiologists participating in existing simulation-based MOC courses at one of eight simulation centers.[31]
- Based on a literature review, the author discusses how obstetric simulation and simulation hands-on courses, used by the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, and the ABOG, fulfill continuing certification/MOC requirements.[32]

Comparison of Continuous Certification to Medical Licensure Actions

- The ABS analyzed loss of license actions for 15,500 general surgeons who were initially certified by the ABS. The study authors found that surgeons who recertified on time following initial board certification (who did not allow their initial certification to lapse) had a significantly lower likelihood of future loss of medical license than those who allowed their initial certification to lapse or never recertified.[33]
- Research that compared the medical license actions of 15,486 anesthesiologists certified between 1994 and 1999 (non–time-limited certificate holders who are not required to participate in MOCA®) and those certified between 2000 and 2005 (time-limited certificate holders who are required to participate in MOCA) showed that board-certified anesthesiologists who met MOCA program requirements were less likely to be disciplined by a state medical licensing agency. There was also evidence that voluntary participation in MOCA by lifetime certificate holders was linked to a lower occurrence of license actions.[34]
- A study that examined the association between family physicians receiving a disciplinary action from a state medical board and certification by the American Board of Family Medicine, using data from 1976 to 2017, showed that 95 percent (114,454 of 120,443) of the family physicians studied had never received any disciplinary action. The authors concluded that family physicians who had ever been ABFM-certified were less likely to receive an action; the most severe actions were associated with decreased odds of being board certified at the time of the action; and receiving the most severe action type increased the likelihood of physicians holding a prior but not current certification.[35]
- A study that compared the association of disciplinary actions with passing the ABIM MOC examination within ten years of initial certification showed that disciplinary actions decreased with better MOC examination scores.[36]

The Importance of Continuous Certification and Physician Satisfaction with Continuous Certification

- A study involving 8,714 diplomates that examined the number of practicing pediatricians who participate in QI activities showed that nearly 87 percent of diplomates indicated participation in a QI project. While maintaining certification was identified as the main driver for participation, respondents also indicated identification of practice gaps, implementing change in practice, and collaborating with others as factors for participation.[37]
- A survey study of 289 dermatologists who completed ABD MOC-focused Practice Improvement (fPI) modules, showed that participants identified the module activities as relevant and helpful in identifying practice gaps. Most participants (254 [87.9 percent]) felt that the activities reaffirmed their practice, and would recommend the fPI modules.[38]
- An evaluation of the ABFM diplomate feedback survey data to examine family physician opinions about ABFM self-assessment module (SAM) content (448,408 SAM feedback surveys were completed within the period 2006-2016) showed that family medicine diplomates generally value SAMs. Respondents felt that the SAM content is appropriate, and favorability ratings increased as diplomates engaged in more SAM activities.[39]
- A study that examined how improving ABFM's SAM content and technical interface could make SAMs more meaningful to ABFM diplomates resulted in mixed feedback between separate modules; overall, respondents indicated satisfaction with and positive reactions to the SAMs, with 80 percent giving SAMs a positive rating. The authors conclude that the results of this study can assist in understanding physicians' perceptions and inform MOC program activities of other specialties.[40]

More than 60 sessions at the ABMS annual QI Forum held during the 2018 ABMS Conference (https://www.abmsconference.com/session-descriptions-2018/) focused on innovations in board certification, the science of assessment and learning, quality improvement, health policy research, and patient safety. Posters presented by the ABMS Portfolio Program™ sponsors and other health care researchers underscored best practices and research in continuing certification and QI activities (https://www.abmsconference.com/posters-2018/).

The Council on Medical Education is committed to monitoring emerging data and the literature to identify improvements to continuing board certification programs, especially those that improve physician satisfaction and patient outcomes and those that enable physicians to keep pace with advances in clinical practice, technology, and assessment.

UPDATE ON OSTEOPATHIC CONTINUOUS CERTIFICATION

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification in several specialties and subspecialties. As of December 31, 2017, 31,762 osteopathic physicians were certified by the AOA and held a combined total of 36,982 active certifications, representing a 7 percent increase over the number of active certifications held in 2016 (34,555). In 2017, 2,206 new certifications were processed as follows:

- Primary specialty: 1,891
- Subspecialty: 224
- Certification of added qualifications (family medicine and preventive medicine only): 91

Additionally, 1,357 OCC completions were processed in 2017.

In January 2017, the AOA impaneled the AOA Certifying Board Services (CBS) Task Force II to address the directive of enhancing board certification services and marketability to make AOA board certification more attractive. Specifically, the Task Force was charged with addressing the following goals:

- Aligning AOA board leadership structure to strengthen physician-led, professionally managed relationships. The demands on CBS have grown substantially, and the expectations placed on the CBS are more than the current system can handle. The goal is to have working physicians serve as the backbone of AOA certification while allowing them to focus on specific tasks that require a physician's skill set and expertise, with administrative support of these efforts delegated to non-physicians.
- Unifying the osteopathic certifying boards through common practices, bylaws, reporting processes, operational alignment, and expenses, and developing uniform, reasonable, and competitive examination fees.

The CBS presented its recommendations to the BOS at its midyear meeting on April 8, 2017. Several of these recommendations are currently being implemented by CBS. For example, board meetings are being aligned into a cluster-based system to facilitate communication. Initiatives to standardize operations to ensure consistent products are also underway.[41] All 18 boards also submitted their new OCC plans to the BOS for review and approval.

The following is a summary of the OCC components listed in the most current BOS Handbook (https://certification.osteopathic.org/wp-content/uploads/2017/05/bos-handbook.pdf):

- Component 1 - Active Licensure:
  AOA board-certified physicians must hold a valid, active license to practice medicine in one of the 50 states or Canada. In addition, they are required to adhere to the AOA's Code of Ethics.

- Component 2 - Life Long Learning/CME:
  CME requirements for diplomates participating in OCC are as follows:
  1. A minimum of 60 CME credits in the specialty area of certification during the specialty boards' 2016-2018 CME cycle.
  2. There are variances across the 18 boards with regards to specific CME inclusions. It is important to refer to each specialty board's website (certification.osteopathic.org) or the current AOA CME Guide (osteopathic.org/cme/cme-guide) for those specifics.

- Component 3 – Cognitive Assessment:
  1. Diplomates must sit for/complete and pass one (or more) psychometrically valid, ongoing assessments during each OCC cycle.
  2. The assessment must evaluate the diplomate's knowledge and skill in the given specialty or subspecialty.

- Component 4 - Practice Performance Improvement and Assessment:
  Diplomates must engage in continuous quality improvement by satisfying one of the following:
  1. Attestation to or online submission of evidence of participation in quality improvement activities.
  2. Completion of Practice Performance Assessment Modules (PPAs) developed by specialty boards and approved by the Standards Review Committee (SRC) of the BOS.

3. Completion of verifiable, quality-driven, or clinically focused encounters that assess the physician's clinical acumen.

CERTIFYING BODIES THAT COMPETE WITH THE ABMS

AMA Policy D-275.954 (39), "Maintenance of Certification and Osteopathic Continuous Certification," asks the AMA to continue studying the certifying bodies that compete with the ABMS. Appendix G provides information on the recertification requirements of the ABMS, AOA, American Board of Physician Specialties, National Board of Physicians and Surgeons (NBPAS), American Board of Facial Plastic and Reconstructive Surgery, and the American Board of Cosmetic Surgery.

In its previous reports,[2-3] the Council noted that wide-scale use of long-standing traditional recertification programs, such as the ABMS MOC, are reflected in training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education. The MOC program was designed to provide a comprehensive approach to physician lifelong learning, self-assessment, and practice improvement, and strives to identify those physicians capable of delivering high-quality specialized medical care.[42]

Newer alternative pathways to specialty board recertification, such as the NBPAS, have been formed to provide a type of recertification that is less rigorous than that obtained via the ABMS MOC process.[43] Ongoing concerns have been registered about administrative burdens, value of the program, relevance and cost of the ABMS MOC process, and time away from patient care. It is important to note that the NBPAS does not have an external assessment or IMP requirements.

AMA policy reinforces the need for ongoing learning and practice improvement and supports the need for an evidence-based certification process that is evaluated regularly to ensure physicians' needs are being met and that activities are relevant to clinical practice. The AMA has adopted extensive policy (H-275.924) that outlines the principles of the ABMS MOC and AOA-BOS OCC and supports the intent of these programs.

CURRENT AMA POLICIES RELATED TO MOC AND OCC

The ABMS Board of Directors is currently using a new name, "Continuing Board Certification," for its MOC Program (although some ABMS member boards are still referring to the program as MOC). To be consistent with this change, this report recommends that the terms "Maintenance of Certification" that appear in the title and body of HOD Policies H-275.924, "AMA Principles on Maintenance of Certification," and D-275.954, "Maintenance of Certification and Osteopathic Continuous Certification," should be changed to "Continuing Board Certification" or "CBC" as shown in Appendix H.

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education is committed to ensuring that continuing board certification programs support physicians' ongoing learning and practice improvement and serve to assure the public that physicians are providing high-quality patient care. The AMA will continue to advocate for a certification process that is evidence-based and relevant to clinical practice as well as cost-effective and inclusive to reduce duplication of work. During the last year, the Council has continued to monitor the development of continuing board certification programs and to work with the ABMS, ABMS member boards, AOA, and state and specialty medical societies to identify and

suggest improvements to these programs. The AMA has also been involved in the Continuing Board Certification: Vision for the Future Commission and in the development of the Commission's recommendations for the future continuing board certification process.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 316-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification. (Directive to Take Action)

2. That our AMA, to be consistent with terminology now used by the American Board of Medical Specialties, amend the following policies by addition and deletion to read as follows:

   Policy H-275.924, Amend the title to read, "~~Maintenance of~~ Continuing Board Certification" (AMA Principles on ~~Maintenance of~~ Continuing Board Certification), and replace the terms "Maintenance of Certification" and "MOC" with "Continuing Board Certification" and "CBC" throughout the policy, as shown in Appendix H.

   Policy D-275.954, Amend the title to read, "~~Maintenance of Certification and Osteopathic Continuous Certification~~ Continuing Board Certification," and replace the terms "Maintenance of Certification" and "MOC" with "Continuing Board Certification" and "CBC" throughout the policy, as shown in Appendix H. (Modify Current HOD Policy)

3. That our AMA rescind Policy D-275.954 (37), "Maintenance of Certification and Osteopathic Continuous Certification," that asks the AMA to "Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission," as this has been accomplished. (Rescind HOD Policy)

4. That our AMA rescind Policy D-275.954 (38), which asks our AMA to "Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards," as this has been accomplished. (Rescind HOD Policy)

5. That our AMA rescind Policy D- 275.954 (39) "Maintenance of Certification and Osteopathic Continuous Certification," as this has been accomplished through this report. (Rescind HOD Policy)

Fiscal Note: $2,500.

APPENDIX A

AMA
AMERICAN MEDICAL ASSOCIATION

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January 15, 2019

Christopher Colenda, MD, MPH
William J. Scanlon, PhD
Co-Chairs, Continuing Board Certification: Vision for the Future Commission

Dear Drs. Colenda and Scanlon,

Thank you for the opportunity to review and comment on the draft report and recommendations from the Continuing Board Certification: Vision for the Future Commission (the "Commission"). The American Medical Association (AMA) Council on Medical Education (the "Council") values your efforts to make continuing certification more relevant, meaningful, and of value to both physicians and patients alike.

The Council applauds the Commission not only for producing such a thorough report, but equally for acknowledging long-standing physician frustrations, such as the concern that the benefits of the continuing certification process traditionally have not been worth the time or financial investment required for participation.

As the report and recommendations are finalized, the Council invites the Commission to consider the following comments.

Preamble

The Council strongly objects to the second paragraph of the section "Purpose and Value of Continuing Certification" on page 7 of the Preamble (which starts, "A fundamental axiom…").

Historically, diplomates have consistently and vocally expressed concern regarding linkages between continuing certification and licensure, and AMA policy with respect to this issue explicitly rejects any such association. Additionally, renewal of licensure in many states is primarily based on completion of CME hours; this does not support the general premise of this report, which argues that rigorous standards must be met to achieve meaningful lifelong learning and assure patient safety.

The Council, therefore, recommends that this paragraph be carefully considered and rewritten; left as is, it may undermine the thoughtful work that characterizes the remainder of the report.

Recommendation 2
Continuing certification should incorporate assessments that support diplomate learning and retention, identify knowledge and skill gaps, and help diplomates learn advances in the field.

The Commission should employ stronger language regarding secure, high-stakes examinations for knowledge assessment. While the Council believes that flexibility in the certification process is important, the Commission should recommend that all Boards incorporate models based on ongoing assessment and feedback, which are better exemplars of contemporary standards of adult learning principles.

Recommendation 4
Standards for learning and practice improvement must expect diplomate participation and meaningful engagement in both lifelong learning and practice improvement. ABMS Boards should seek to integrate readily available information from a diplomate's actual clinical practice into any assessment of practice improvement.

The Commission should recommend that all Boards utilize stronger language regarding the acceptance of quality data already being reported by individual physicians. If a physician is actively participating in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) via the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM), the Commission should recommend that all Boards accept this participation as a satisfactory requirement for certification.

Recommendation 5
ABMS Boards have the responsibility and obligation to change a diplomate's certification status when certification standards are not met.

The Council feels strongly that Recommendation 5 should be edited as follows:

"ABMS Boards have the responsibility and obligation to change a diplomate's continuing certification status when continuing certification standards are not met."

Likewise, the first sentence of the explanation for Recommendation 5 should be modified:

"The Commission supports the ABMS Boards in making decisions about the continuing certification status of a diplomate and changing the diplomate's status when continuing certification standards are not met."

At no time can a Board revoke or change an individual physician's original certification solely on the basis of non-participation in the continuing certification process.

Recommendation 8
The certificate has value, meaning and purpose in the health care environment.

Although the report does specify that board certification should not be tied to credentialing, there is no parallel mention of this with respect to medical licensure. The Commission should address this explicitly to assuage long-held and expressed concerns that the Federation of State Medical Boards (FSMB) may at some point tie certification to licensure (although the Council recognizes that this is not the current policy of the FSMB).

Recommendation 11
ABMS Boards must comply with all ABMS certification and organizational standards.

The Council notes that while financial transparency is included in the findings of both Recommendations 10 and 11, it is not specifically referenced in either of the Recommendations themselves. Detailed financial transparency regarding fiscal responsibility toward diplomates must be a cornerstone of all Board models, and may help communicate the message that the concerns of many diplomates who have expressed anxiety on this point have been heard and are being addressed.

The Council applauds the report for its recommendation of inclusion with respect to Board composition; the Commission may wish specifically to include mention of young physicians.

Recommendation 14
ABMS Boards should have consistent certification processes for certain elements.

The Council appreciates the intention behind this Recommendation, and recognizes that diplomates of certain Boards have expressed frustration regarding their individual Board's lack of momentum with respect to innovation. While it may make sense to standardize terminology across Boards, a more cautious approach may be appropriate when thinking about standardization of processes, as different specialties require varied approaches to ongoing certification and diplomates in many specialties are satisfied with their individual Board's innovations to date.

The Council, therefore, recommends that the Commission strongly encourage the ABMS to develop and publicly share its plans to actively oversee and navigate its approach to consistency. The Council also recommends that the Commission strongly encourage the ABMS to consider the negative public impact that less innovative Boards may be having on those that have dedicated significant time and resources to improving their processes for diplomates. Further, the Council recommends that the Commission encourage the ABMS to publicize its newly established Accountability and Resolution Committee (ARC), tasked with addressing and making recommendations to resolve complaints and problems related to non-compliance, both organizational and individual, that have not been resolved through other mechanisms, and to ensure that the ARC's processes and decisions are transparent to the public.

General Comments

- The Council feels that the final sentence in the Concluding Comments, which references "better doctors," is somewhat subjective, and suggests that the Commission consider language that recognizes the importance of doctors who remain current in the appropriate competencies to best serve their patients.

- Continuing medical education (CME) activities are discussed in detail on page 18 of the report. The Commission may wish to modify the sentence that references the ACCME, as entities beyond the ACCME are involved in this important process:

  "Those involved in developing and approving CME activities, and setting standards for such activities, should be encouraged to establish processes to encourage high quality CME and remediate or eliminate lower quality activities."

- Page 21 of the report focuses on the public's expectations. The Council believes it is important to acknowledge that continuing certification is but one component to promote patient safety and quality. Health care is a systems-based team effort, and changes to continuing certification should not create the unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

Again, thank you for the opportunity to participate in this important process. If the Council may be of further assistance to you in this matter, please do not hesitate to communicate with us.

Sincerely,

Jacqueline A. Bello, MD, FACR
Chair-Elect, AMA Council on Medical Education

cc: Susan E. Skochelak, MD
Richard E. Hawkins, MD

APPENDIX B

Impact of the Council on Medical Education's Comments on the Final Recommendations of the Continuing Board Certification: Vision for the Future Commission

Draft Recommendations/Council on Medical Education Comments	Final Recommendations*
2. Continuing certification should incorporate assessments that support diplomate learning and retention, identify knowledge and skill gaps, and help diplomates learn advances in the field. The Commission should employ stronger language regarding secure, high-stakes examinations for knowledge assessment. While the Council believes that flexibility in the certification process is important, the Commission should recommend that all Boards incorporate models based on ongoing assessment and feedback, which are better exemplars of contemporary standards of adult learning principles.	2. Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.
4. Standards for learning and practice improvement must expect diplomate participation and meaningful engagement in both lifelong learning and practice improvement. ABMS Boards should seek to integrate readily available information from a diplomate's actual clinical practice into any assessment of practice improvement. The Commission should recommend that all Boards utilize stronger language regarding the acceptance of quality data already being reported by individual physicians. If a physician is actively participating in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) via the Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM), the Commission should recommend that all Boards accept this participation as a satisfactory requirement for certification.	13. ABMS and the ABMS Boards should collaborate with specialty societies, the CME/CPD community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice. The ABMS Boards must ensure that their continuing certification programs recognize and document participation in a wide range of quality assessment activities in which diplomates already engage.
5. ABMS Boards have the responsibility and obligation to change a diplomate's certification status when certification standards are not met. Recommendation 5 should be edited as follows: "ABMS Boards have the responsibility and obligation to change a diplomate's continuing certification status when continuing certification standards are not met." Likewise, the first sentence of the explanation for Recommendation 5 should be modified: "The Commission supports the ABMS Boards in making decisions about the continuing certification status of a diplomate and changing the diplomate's status when continuing certification standards are not met." At no time can a Board revoke or change an individual physician's original certification solely on the basis of non-participation in the continuing certification process.	7. The ABMS Boards must change a diplomate's certification status when continuing certification standards are not met.

8. The certificate has value, meaning and purpose in the health care environment. Although the report does specify that board certification should not be tied to credentialing, there is no parallel mention of this with respect to medical licensure. The Commission should address this explicitly to assuage long-held and expressed concerns that the Federation of State Medical Boards (FSMB) may at some point tie certification to licensure (although the Council recognizes that this is not the current policy of the FSMB).	11. ABMS must demonstrate and communicate that continuing certification has value, meaning, and purpose in the health care environment. a. Hospitals, health systems, payers and other health care organizations can independently decide what factors are used in credentialing and privileging decisions. b. ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions. c. ABMS must encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.
11. ABMS Boards must comply with all ABMS certification and organizational standards. While financial transparency is included in the findings of both Recommendations 10 and 11, it is not specifically referenced in either of the Recommendations themselves. Detailed financial transparency regarding fiscal responsibility toward diplomates must be a cornerstone of all Board models, and may help communicate the message that the concerns of many diplomates who have expressed anxiety on this point have been heard and are being addressed. The Council applauds the report for its recommendation of inclusion with respect to Board composition; the Commission may wish specifically to include mention of young physicians.	10. The ABMS Boards must comply with all ABMS certification and organizational standards, including financial stewardship and ensuring that diverse groups of practicing physicians and the public voice are represented.
14. ABMS Boards should have consistent certification processes for certain elements. The Council appreciates the intention behind this Recommendation, and recognizes that diplomates of certain Boards have expressed frustration regarding their individual Board's lack of momentum with respect to innovation. While it may make sense to standardize terminology across Boards, a more cautious approach may be appropriate when thinking about standardization of processes, as different specialties require varied approaches to ongoing certification and diplomates in many specialties are satisfied with their individual Board's innovations to date. The Council, therefore, recommends that the Commission strongly encourage the ABMS to develop and publicly share its plans to actively oversee and navigate its approach to consistency. The Council also recommends that the Commission strongly encourage the ABMS to consider the negative public impact that less innovative Boards may be having on those that have dedicated significant time and resources to improving their processes for diplomates. Further, the Council recommends that the Commission encourage the ABMS to publicize its newly established Accountability and Resolution Committee (ARC), tasked with addressing and	4. The ABMS and the ABMS Boards must have consistent processes and requirements for continuing certification that are fair, equitable, transparent, effective, and efficient.

making recommendations to resolve complaints and problems related to non-compliance, both organizational and individual, that have not been resolved through other mechanisms, and to ensure that the ARC's processes and decisions are transparent to the public.	

* Several of the final recommendations were revised, reorganized, and renumbered in the Continuing Board Certification: Vision for the Future Commission's Final Report.

APPENDIX C

Final Recommendations of the Continuing Board Certification: Vision for the Future Commission and Related AMA Policy

Final Recommendations	Related AMA Policy
1. Continuing certification must integrate professionalism, assessment, lifelong learning, and advancing practice to determine the continuing certification status of a diplomate.	H-300.958 (7) Our AMA affirms that lifelong learning is a fundamental obligation of our profession and recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physician' s medical practice as determined by the relevant specialty society.
2. Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.	H-275.924 (22) There should be multiple options for how an assessment could be structured to accommodate different learning styles. D-275.954 Our AMA will…(5) Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination. (29) Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination. (31) Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam. (36) Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
3. The ABMS Boards must regularly communicate with their diplomates about the standards for the specialty and encourage feedback about the program.	H-275.924 (13) The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. D-275.954 Our AMA will…(19) Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements. (20) Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
4. The ABMS and the ABMS Boards must have consistent processes and requirements for continuing certification that are fair, equitable, transparent, effective, and efficient.	H-275.924 (19) The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care. (27) Our AMA will continue to work with the national medical specialty societies to advocate for the

	physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
5. The ABMS Boards must enable multi-specialty and subspecialty diplomates to remain certified across multiple ABMS Boards without duplication of effort.	D-275.954 Our AMA will…(11) Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
6. ABMS and the ABMS Boards must facilitate and encourage independent research to build on the existing evidence base about the value of continuing certification.	D-275.954 Our AMA will…(3) Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis. (4) Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
7. The ABMS Boards must change a diplomate's certification status when continuing certification standards are not met.	H-275.924 (24) No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC. (26) The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.
8. The ABMS Boards must have clearly defined remediation pathways to enable diplomates to meet continuing certification standards in advance of and following any loss of certification.	D-295.325 (4) Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills.
9. ABMS and the ABMS Boards must make publicly available the certification history of all diplomates, including their participation in the continuing certification process. The ABMS Boards must facilitate voluntary re-engagement into the continuing certification process for lifetime certificate holders and others not currently participating in the continuing certification process.	H-275.924 (24) No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC. (26) The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.

10. The ABMS Boards must comply with all ABMS certification and organizational standards, including financial stewardship and ensuring that diverse groups of practicing physicians and the public voice are represented.	H-275.924 (27) Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes. D-275.954 Our AMA will…(10) Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. ABMS must demonstrate and communicate that continuing certification has value, meaning, and purpose in the health care environment. a. Hospitals, health systems, payers and other health care organizations can independently decide what factors are used in credentialing and privileging decisions. b. ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions. c. ABMS must encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.	H-275.924 (15) The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation. (27) Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes. D-275.954 Our AMA will…(6) Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians. (33) Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
12. ABMS and the ABMS Boards must seek input from other stakeholder organizations to develop consistent approaches to evaluate professionalism and professional standing while ensuring due process for the diplomate when questions of professionalism arise.	9.4.1 Peer Review & Due Process. Physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physician' right to

	exercise medical judgment freely with the obligation to do so wisely and temperately. Fairness is essential in all disciplinary or other hearings where the reputation, professional status, or livelihood of the physician or medical student may be adversely affected. Individually, physicians and medical students who are involved in reviewing the conduct of fellow professionals, medical students, residents or fellows should: (a) Always adhere to principles of a fair and objective hearing, including: (i) a listing of specific charges, (ii) adequate notice of the right of a hearing, (iii) the opportunity to be present and to rebut the evidence, and (iv) the opportunity to present a defense. (b) Ensure that the reviewing body includes a significant number of persons at a similar level of training. (c) Disclose relevant conflicts of interest and, when appropriate, recuse themselves from a hearing. Collectively, through the medical societies and institutions with which they are affiliated, physicians should ensure that such bodies provide procedural safeguards for due process in their constitutions and bylaws or policies.
13. ABMS and the ABMS Boards should collaborate with specialty societies, the CME/CPD community, and other expert stakeholders to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice. The ABMS Boards must ensure that their continuing certification programs recognize and document participation in a wide range of quality assessment activities in which diplomates already engage.	D-275.954 Our AMA will…(12) Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements. (18) Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
14. The ABMS Boards must collaborate with professional and/or CME/CPD organizations to share data and information to guide and support diplomate engagement in continuing certification.	D-275.954 Our AMA will…(30) Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

APPENDIX D

Current HOD Policies Related to Maintenance of Certification and Osteopathic Continuous Certification

H-275.924, Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
(CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17)"

D-275.954, Maintenance of Certification and Osteopathic Continuous Certification
Our AMA will:
1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.
38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.
39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education s annual report on maintenance of certification at the 2019 Annual Meeting.
(CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18)

APPENDIX E

ABMS Committee on Continuing Certification (3C) Supplemental Information

1. List of ABMS pilots and substantive changes approved at 3C Meetings

APPROVED – Substantive Changes

Board	MOC Component	Pilot	Announced	Approved
American Board of Anesthesiology	Assessment of Knowledge, Judgment, and Skills	MOCA Minute	April 2015	April 2018
American Board of Thoracic Surgery	Assessment of Knowledge, Judgment, and Skills	Mastery Learning Process Using SESATS	April 2015	November 2015
American Board of Pathology	Assessment of Knowledge, Judgment, and Skills	Remote Proctoring	April 2015	July 2016
American Board of Dermatology	Improvement in Medical Practice	Practice Improvement Pilot	November 2015	April 2018
American Board of Obstetrics and Gynecology	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Integration of MOC Parts II & III	November 2015	April 2018
American Board of Emergency Medicine	Professionalism and Professional Standing	Improvements to Communication/Professionalism Requirement	April 2016	April 2018
American Board of Pediatrics	Assessment of Knowledge, Judgment, and Skills	MOCAPeds	November 2016	April 2018
American Board of Emergency Medicine	Lifelong Learning and Self-Assessment	Lifelong Learning and Self-Assessment Requirements Update	November 2018	November 2018

2. List of ABMS active pilots announced at 3C Meetings

ACTIVE - Pilots

Board	MOC Component	Pilot	Announced
American Board of Internal Medicine	Improvement in Medical Practice	Improvements to Part IV	April 2015
American Board of Neurological Surgery	Assessment of Knowledge, Judgment, and Skills	Cognitive Assessment/Learning Tool	November 2016
American Board of Radiology	Assessment of Knowledge, Judgment, and Skills	Online Longitudinal Assessment (OLA)	November 2016
American Board of Ophthalmology	Assessment of Knowledge, Judgment, and Skills	Quarterly Questions	November 2016
American Board of Pathology	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2016
American Board of Medical Genetics and Genomics	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2017
American Board of Nuclear Medicine	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2017
American Board of Allergy and Immunology	Assessment of Knowledge, Judgment, and Skills	Continuous Assessment Program	April 2017
American Board of Internal Medicine	Assessment of Knowledge, Judgment, and Skills	Knowledge Check-Ins	April 2017
American Board of Colon and Rectal Surgery	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2017
American Board of Physical Medical and Rehabilitation	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	November 2017
American Board of Plastic Surgery	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Lifelong Learning and Self-Assessment and Knowledge, Judgment, and Skills	November 2017
American Board of Psychiatry and Neurology	Lifelong Learning and Self-Assessment, Knowledge, Judgment, and Skills	Lifelong Learning and Self-Assessment and Knowledge, Judgment, and Skills	November 2017
American Board of Surgery	Assessment of Knowledge, Judgment, and Skills	New Assessment Process	November 2017

American Board of Otolaryngology – Head and Neck Surgery	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	April 2018
American Board of Orthopaedic Surgery	Assessment of Knowledge, Judgment, and Skills	Web-based Longitudinal Assessment (WLA)	April 2018
American Board of Emergency Medicine	Assessment of Knowledge, Judgment, and Skills	MyEMCert	April 2018
American Board of Dermatology	Assessment of Knowledge, Judgment, and Skills	Longitudinal Assessment Program: CertLink	July 2018
American Board of Family Medicine	Assessment of Knowledge, Judgment, and Skills	Family Medicine Certification Longitudinal Assessment	November 2018

APPENDIX F

Improvements to the American Board of Medical Specialties (ABMS) Part III, Assessment of Knowledge, Judgment, and Skills and Part IV, Improvement in Medical Practice*

American Board of:	Original Format	New Models/Innovations
Allergy and Immunology (ABAI) abai.org	**Part III:** Computer-based, secure exam was administered at a proctored test center once a year. Diplomates were required to pass the exam once every 10 years.	**Part III:** In 2018, ABAI-Continuous Assessment Program Pilot was implemented in place of current exam: • A 10-year program with two 5-year cycles; • Diplomates take exam where and when it is convenient; • Open-book annual exam with approximately 80 questions; • Mostly article-based with some core questions during each 6-month cycle. Diplomates must answer three questions for each of ten journal articles in each cycle. The articles are posted in January and July and remain open for 6 months. • Questions can be answered independently for each article; • Diplomate feedback required on each question; • Opportunity to drop the two lowest 6-month cycle scores during each 5-year period to allow for unexpected life events; and • Ability to complete questions on PCs, laptops, MACs, tablets, and smart phones by using the new diplomate dashboard accessed via the existing ABAI Web Portal page.
	Part IV[2]: ABAI diplomates receive credit for participation in registries.	**Part IV[2]:** In 2018, new Part IV qualifying activities provided credit for a greater range of improvement in medical practice (IMP) activities that physicians complete at their institutions and/or individual practices. A practice assessment/quality improvement (QI) module must be completed once every 5 years.
Anesthesiology (ABA) theaba.org	**Part III:** MOCA 2.0 introduced in 2014 to provide a tool for ongoing low-stakes assessment with more extensive, question-specific feedback. Also provides focused content that could be reviewed periodically to refresh knowledge and document cognitive expertise.	**Part III:** MOCA Minute® replaced the MOCA exam. Diplomates must answer 30 questions per calendar quarter (120 per year), no matter how many certifications they are maintaining.

	All diplomates with time-limited certification in anesthesiology that expired on or before December 31, 2015 and diplomates whose subspecialty certificates expired on or before December 31, 2016, must complete the traditional MOCA® requirements before they can register for MOCA 2.0®.	
	Part IV[2]: Traditional MOCA requirements include completion of case evaluation and simulation course during the 10-year MOCA cycle. One activity must be completed between Years 1 to 5, and the second between Years 6 to 10. An attestation is due in Year 9.	**Part IV[3-4]:** ABA is adding and expanding multiple activities for diplomates to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement. Diplomates may choose activities that are most relevant to their practice; reporting templates no longer required for self-report activities; simulation activity no longer required following diplomate feedback that it was expensive and time-consuming.
Colon and Rectal Surgery (ABCRS) abcrs.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (in May). Diplomates must pass the exam once every 10 years.	**Part III[1]:** ABCRS is exploring ways to modify the exam experience to provide a more consistent assessment process and to replace the exam as it presently is administered. The first diplomates enrolled in CertLink™ MOC included those sitting for the ABCRS certifying exam in September 2017. These diplomates started CertLink™ MOC in the Spring of 2018. Other diplomates will be able to enroll in the near future. The computer-based secure exam will not be offered after 2019.
	Part IV: Requires ongoing participation in a local, regional, or national outcomes registry or quality assessment program.	**Part IV[3-4]:**
Dermatology (ABD) abderm.org	**Part III:** Computer-based secure modular exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Test preparation material available 6 months before the exam at no cost. The material includes diagnoses from which the general dermatology clinical images will be drawn and questions that will be used to generate the subspecialty modular exams.	**Part III[1]:** ABD successfully completed trials employing remote proctoring technology to monitor exam administration in the diplomates' homes or offices. ABD is developing a longitudinal assessment as an alternative to the traditional MOC exam (pilot scheduled for 2019, launch tentatively scheduled for 2020).

	Examinees are required to take the general dermatology module, consisting of 100 clinical images to assess diagnostic skills, and can then choose among 50-item subspecialty modules.	
	Part IV[2]: Tools diplomates can use for Part IV include: • Focused practice improvement modules. • ABD's basal cell carcinoma registry tool. Partnering with specialty society to transfer any MOC-related credit directly to Board.	**Part IV:** ABD developed more than 40 focused practice improvement modules that are simpler to complete and cover a wide range of topics to accommodate different practice types. Peer and patient communication surveys are now optional.
Emergency Medicine (ABEM) abem.org	**Part III:** ABEM's ConCert™, computer-based, secure exam administered at a proctored test center twice a year. Diplomates must pass the exam once every 10 years.	**Part III:** In 2020, a second way to demonstrate physicians continue to possess the knowledge and cognitive skills of an ABEM-certified emergency physician—MyEMCert—will be piloted. MyEMCert will consist of: Shorter, more frequent tests: Each test will assess one or more specific content areas relevant to the clinical practice of emergency medicine, such as cardiovascular disorders or trauma. The tests will be about an hour long, with. the ability to retake a test again if it is not passed the first time, providing: physicians with a clearer idea of what topics need to be reviewed. Physicians will take the test remotely and have access to references.
	Part IV[2]: Physicians may complete practice improvement efforts related to any of the measures or activities listed on the ABEM website. Others that are not listed, may be acceptable if they follow the four steps ABEM requirements.	**Part IV:** ABEM is developing a pilot program to incorporate clinical data registry. ABEM diplomates receive credit for improvements they are making in their practice setting.
Family Medicine (ABFM) theabfm.org	**Part III:** Computer-based secure exam administered at a proctored test center twice a year or by remote proctoring technology. Diplomates must pass the exam once every 10 years. Improving relevance of exam by using national study of care content in family medicine practices. Providing feedback to residents and practicing physicians about the "anatomy" of the exam and their specific knowledge gaps (this effort has resulted in significant	**Part III:** In December 2018, the ABFM launched a pilot to study the feasibility and validity of an alternative to the 10-year examination, called Family Medicine Certification Longitudinal Assessment (FMCLA). Limited to diplomates who are currently certified and are in the tenth year of certification due to end December 31, 2019, this approach is more aligned with adult learning principles, and when coupled with modern technology, promotes more enduring learning, retention, and

	improvement in passing rates and improved feedback regarding relevance).	transfer of knowledge than episodic examinations.
	Part IV[2]: IMP Projects include: • Collaborative Projects: Structured projects that involve physician teams collaborating across practice sites and/or institutions to implement strategies designed to improve care. • Projects Initiated in the Workplace: These projects are based on identified gaps in quality in a local or small group setting. • Web-based Activities: Self-paced activities that physicians complete within their practice setting (these activities are for physicians, who do not have access to other practice improvement initiatives).	**Part IV[2-3]:** ABFM developed and launched the national primary care registry (PRIME) to reduce time and reporting requirements.
Internal Medicine (ABIM) abim.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. ABIM introduced grace period for physicians to retry assessments for additional study and preparation if initially unsuccessful.	**Part III:** In 2018, two assessment options were offered: 1) Certified physicians (internal medicine, cardiovascular disease, geriatric medicine, endocrinology, diabetes, and metabolism, gastroenterology, hematology, infectious disease, nephrology, pulmonary disease, and rheumatology with more specialties to roll out in 2020) will be eligible to take the Knowledge Check-In, a new 2-year open-book (access to *UpToDate*®) assessment with immediate performance feedback. Assessments can be taken at the physician's home or office or at a computer testing facility instead of taking the long-form exam every 10 years at a testing facility. Those who meet a performance standard on shorter assessments will not need to take the 10-year exam again to remain certified. 2) Diplomates can also choose to take a long-form assessment given every 10 years. This option is the same as the current 10-year exam, but it will include open-book access (to *UpToDate*®) that physicians requested. *ABIM is also working with specialty societies to explore the development of collaborative pathways through which*

		physicians can maintain board certification.
	Part IV[2]: Practice assessment/QI activities include identifying an improvement opportunity in practice, implementing a change to address that opportunity, and measuring the impact of the change. Diplomates can earn MOC points for many practice assessment/QI projects through their medical specialty societies, hospitals, medical groups, clinics, or other health-related organizations.	**Part IV:** Increasing number of specialty-specific IMP activities recognized for credit (activities that physicians are participating in within local practice and institutions).
Medical Genetics and Genomics (ABMGG) abmgg.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (August). Diplomates must pass the exam once every 10 years.	**Part III[1]:** In 2018, CertLink Pilot Program launched: • Twenty-four questions distributed every 6 months throughout pilot period, regardless of number of specialties in which a diplomate is certified; • All questions must be answered by end of each 6-month timeframe (~5 minutes allotted per question); • Resources allowed, collaboration with colleagues not allowed; • Realtime feedback and performance provided for each question; and • "Clones" of missed questions will appear in later timeframes to help reinforce learning.
	Part IV[2]: Diplomates can choose from the list of options to complete practice improvement modules in areas consistent with the scope of their practice.	**Part IV[3-4]:** ABMGG is developing opportunities to allow diplomates to use activities already completed at their workplace to fulfill certain requirements. Expanding accepted practice improvement activities for laboratorians.
Neurological Surgery (ABNS) abns.org	**Part III:** The 10-year secure exam can be taken from any computer, i.e., in the diplomate's office or home. Access to reference materials is not restricted; it is an open book exam. On applying to take the exam, a diplomate must assign a person to be his or her proctor. Prior to the exam, that individual will participate in an on-line training session and "certify" the exam computers.	**Part III:** In 2018, the 10-year exam was replaced with an annual adaptive cognitive learning tool, Core Neurosurgical Knowledge: • Open book exam focusing on 30 or so evidence-based practice principles critical to emergency, urgent, or critical care; • Shorter, relevant, and more focused questions than the prior exam;

		• Web-based format with 24/7 access from the diplomates' home or office; and • Immediate feedback to each question and references with links and/or articles are provided.
	Part IV: Diplomates receive credit for documented participation in an institutional QI project.	**Part IV:** Diplomates are required to participate in a meaningful way in morbidity and morality conferences at his or her primary hospital. For those diplomates participating in the Pediatric Neurosurgery, CNS-ES, NeuCC focused practice programs, a streamlined case log is required to confirm that their practice continues to be focused and the diplomate is required to complete a learning tool that includes core neurosurgery topics and an additional eight evidence-based concepts critical to providing emergency, urgent, or critical care in their area of focus.
Nuclear Medicine (ABNM) abnm.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years.	**Part III[1]:** Diplomates can choose between the 10-year exam or a longitudinal assessment pilot program (CertLink™). CertLink™ periodically delivers nuclear medicine questions with detailed explanations and references directly to diplomates.
	Part IV: Diplomates must complete one of the three following requirements each year. 1) Attestation that the diplomate has participated in QI activities as part of routine clinical practice, such as participation in a peer review process, attendance at tumor boards, or membership on a radiation safety committee. 2) Participation in an annual practice survey related to approved clinical guidelines released by the ABNM. The survey has several questions based on review of actual cases. Diplomates receive a summary of the answers provided by other physicians that allows them to compare their practice to peers. 3) Improvement in medical practice projects designed by diplomates, or provided by professional groups such as the Society of Nuclear Medicine and Molecular Imaging (SNMMI). Project areas may include medical care provided	**Part IV[3-4]:** ABNM recognizes QI activities in which physicians participate in their clinical practice.

	for common/major health conditions, physician behaviors, such as communication and professionalism, as they relate to patient care, and many others. The projects typically follow the model of Plan-Do-Study-Act. The ABNM has developed a few IMP modules for the SNMMI, Alternatively, diplomates may design their own project.	
Obstetrics and Gynecology (ABOG) abog.org	**Part III:** The secure, external assessment is offered in the last year of each ABOG diplomate's 6-year cycle in a modular test format; diplomates can choose two selections that are the most relevant to their current practice.	**Part III:** ABOG completed a pilot program and integrated the article-based self-assessment (Part II) and external assessment (Part III) requirements, allowing diplomates to continuously demonstrate their knowledge of the specialty. The pilot allowed diplomates to earn an exemption from the current computer-based exam in the sixth year of the program if they reach a threshold of performance during the first 5 years of the self-assessment program. In 2019, diplomates can choose to take the 6-year exam or participate in Performance Pathway, an article-based self-assessment (with corresponding questions) which showcases new research studies, practice guidelines, recommendations, and up-to-date reviews. Diplomates who participate in Performance Pathway are required to read a total of 180 selected articles and answer 720 questions about the articles over the 6-year MOC cycle.
	Part IV[2]: Diplomates required to participate in one of the available IMP activities yearly in MOC Years 1-5. ABOG will consider structured QI projects (IMP modules, QI efforts, simulation courses) in obstetrics and gynecology for Part IV credit. These projects must demonstrate improvement in care and be based on accepted improvement science and methodology. Newly developed QI projects from organizations with a history of successful QI projects are also eligible for approval.	**Part IV:** ABOG recognizes work with QI registries for credit. ABOG continues to expand the list of approved activities which can be used to complete the Part IV. The number of hours required for approval of simulation course credit has been decreased to 4 hours of instruction.

Ophthalmology (ABO) abop.org	**Part III:** The Demonstration of Ophthalmic Cognitive Knowledge (DOCK) high-stakes, 10-year exam administered through 2018.	**Part III:** In 2019, Quarterly Questions™ will replace the DOCK Examination for all diplomates: • Will deliver 50 questions (40 knowledge-based and 10 article-based); • Offered remotely at home or office through computer, tablet, or mobile apps; • The questions should not require preparation in advance, but a content outline for the multiple-choice questions will be available; • Diplomates will receive instant feedback and recommendations for resources related to gaps in knowledge; and • Key ophthalmic journal articles with questions focused on the application of this information to patient care. The journal portion will require reading five articles from a list of 30 options.
	Part IV[2]: Diplomates whose certificates expire on or before December 31, 2020 must complete one of the following options; all other diplomates complete two activities: 1) Read QI articles through Quarterly Questions; 2) Choose a QI CME activity; 3) Create an individual IMP activity; or 4) Participate in the ABMS multi-specialty portfolio program pathway.	**Part IV[3-4]:** Diplomates can choose to: 1) Design a registry-based IMP Project using their AAO IRIS® Registry Data; 2) Create a customized, self-directed IMP activity; or 3) Participate in the ABMS multi-specialty portfolio program through their institution.
Orthopaedic Surgery (ABOS) abos.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. The optional oral exam is given in Chicago in July. Diplomates without subspecialty certifications can take practice-profiled exams in orthopaedic sports medicine and surgery of the hand. General orthopaedic questions were eliminated from the practice-profiled exams so diplomates are only tested in areas relevant to their practice. Detailed blueprints are being produced for all exams to provide additional information for candidates to prepare for and complete the exams.	**Part III:** In 2019, a new web-based longitudinal assessment program (ABOS WLA) the Knowledge Assessment, will be piloted. ABOS diplomates may choose this pathway instead of an ABOS computer-based or oral recertification 10-year exam: • Offered remotely at home or office through computer, tablet, or mobile apps; • Thirty questions must be answered between April 15, 2019 and May 20, 2019 (two questions will come from each Knowledge Source). • The assessment is open-book and diplomates can use the Knowledge Sources, if the questions are answered within the 3-minute window and that the answer

	Eight different practice-profiled exams offered to allow assessment in the diplomate's practice area.	represents the diplomate's own work.
	Part IV[2]: Case lists allow diplomates to review their practice including adhering to accepted standards, patient outcomes, and rate and type of complications. Case list collection begins on January 1st of the calendar year that the diplomate plans to submit their recertification application, and is due by December 1. The ABOS recommends that this be done in Year 7 of the 10-year MOC Cycle, but it can be done in Year 8 or 9. A minimum of 35 cases is required for the recertification candidate to sit for the recertification exam of their choice. Diplomates receive a feedback report based on their submitted case list.	**Part IV[3-4]:** ABOS is streamlining the case list entry process to make it easier to enter cases and classify complications.
Otolaryngology – Head and Neck Surgery (ABOHNS) aboto.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III[1]:** ABOHNS is piloting a CertLink™-based longitudinal assessment in 2019 (20 questions per quarter) to explore and evaluate assessment methods to provide immediate, personalized feedback as an alternative to the high-stakes exam. Diplomates whose certificates expire in 2019 are eligible to participate on a voluntary basis.
	Part IV[2]: The three components of Part IV include: 1) A patient survey; 2) A peer survey; and 3) A registry that will be the basis for QI activities.	**Part IV:** ABOHNS is partnering with the American Academy of Otolaryngology-Head and Neck Surgery in their development of a RegentSM registry. Selected data will be extracted from RegentSM for use in practice improvement modules that diplomates can use to meet IMP requirements.
Pathology (ABPath) abpath.org	**Part III:** Computer-based secure modular exam administered at the ABP Exam Center in Tampa, Florida twice a year (March and August). Remote computer exams can be taken anytime 24/7 that the physician chooses during the assigned 2-week period (spring and fall) from their home or office.	**Part III[1]:** The ABPath CertLink® pilot program is available for all diplomates: • Diplomates can log in anytime to answer 15 multiple-choice questions assigned per quarter; • Each question must be answered within 5 minutes; • Can use any resources (e.g. internet, textbooks, journals) except another person; • Immediate feedback on whether each question is answered correctly

	Physicians can choose from more than 90 modules, covering numerous practice areas for a practice-relevant assessment. *Diplomates must pass the exam once every 10 years.*	or incorrectly, with a short narrative about the topic (critique), and references; and • Customization allows diplomates to select questions from practice (content) areas relevant to their practice.
	Part IV[2]: Diplomates must participate in at least one inter-laboratory performance improvement and quality assurance programs per year appropriate for the spectrum of anatomic and clinical laboratory procedures performed in that laboratory.	**Part IV[3-4]:**
Pediatrics (ABP) abp.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III:** In 2019 Maintenance of Certification Assessment for Pediatrics (MOCA-Peds), a new testing platform with shorter and more frequent assessments, will be rolled out • A series of questions released through mobile devices or a web browser at regular intervals; • Twenty multiple choice questions that are available quarterly and may be answered at any time during the quarter; • Immediate feedback and references; • Resources (i.e., internet, books) can be used when taking the exam; and • Allows for questions to be tailored to the pediatrician's practice profile. Physicians will provide feedback on individual questions so the exam can be continuously improved. Those who wish to continue taking the exam once every 5 years in a secure testing facility will be able to do so.
	Part IV[2]: Diplomates must earn at least 40 points every 5 years, in one of the following activities: • Local or national QI projects • Diplomates' own project • National Committee for Quality Assurance Patient-Centered Medical Home or Specialty Practice • Institutional QI leadership • Online modules (PIMS)	**Part IV:** ABP is enabling new pathways for pediatricians to claim Part IV QI credit for work they are already doing. These pathways are available to physicians who are engaged in QI projects alone or in groups, and include a pathway for institutional leaders in quality to claim credit for their leadership. ABP is also allowing trainees (residents and fellows) to "bank" MOC credit for quality improvement activities in which

		they participate. The pediatricians supervising these trainees also may claim MOC credit for qualifying projects.
Physical Medicine and Rehabilitation (ABPMR) abpmr.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Released MOC 100, a set of free practice questions pulled directly from the ABPMR exam question banks to help physicians prepare for the exam.	**Part III[1]:** ABPMR is conducting a CertLink™-based longitudinal assessment pilot through 2020 to explore and evaluate shorter, more frequent assessment methods and provision of immediate, personalized feedback as an alternative to the high-stakes exam. ABPMR is also working with its specialty society to produce clinical updates that will integrate with the longitudinal assessment tool.
	Part IV[2]: Guided practice improvement projects are available through ABPMR.	**Part IV[3-4]:** ABPMR is introducing several free tools to complete an IMP project, including: simplified and flexible template to document small improvements and educational videos, infographic, and enhanced web pages. ABPMR is seeking approval from the National Committee for Quality Assurance Patient-Centered Specialty Practice Recognition for Part IV IMP credit. ABPMR is also working with its specialty society to develop relevant registry-based QI activities.
Plastic Surgery (ABPS) abplasticsurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Modular exam to ensure relevance to practice. ABPS offers a Part III Study Guide with multiple choice question items derived from the same sources used for the exam.	**Part III:** Piloting online delivery of Part III exam in place of centralized in-person testing center to reduce costs and time away from practice. Diplomates will be given immediate feedback on answers and offered an opportunity to respond again. If successful, this pilot may replace the high-stakes exam. Instituting online longitudinal learning program that will assess the physician's knowledge, provide immediate feedback, and reinforce areas of knowledge deficiency throughout the 5-year cycle.
	Part IV[2]: ABPS provides Part IV credit for registry participation. ABPS also allows Part IV credit for IMP activities that a diplomate is engaged in	**Part IV[3-4]:** Allowing MOC credit for Improvement in Medical Practice activities that a diplomate is engaged in through their hospital or institution.

	through their hospital or institution. Diplomates are asked to input data from 10 cases from any single index procedure every 3 years, and ABPS provides feedback on diplomate data across five index procedures in four subspecialty areas.	Physician participation in one of four options can satisfy the diplomate's Practice Improvement Activity: • Quality improvement publication • Quality improvement project • Registry participation • Tracer procedure log
Preventive Medicine (ABPM) theabpm.org	**Part III:** In-person, pencil-and-paper, secure exam administered at secure test facility. MOC exams follow the same content outline as the initial certification exam (without the core portion). *In 2016, new multispecialty subspecialty of Addiction Medicine was established. In 2017, Addiction Medicine subspecialty certification exam was administered to diplomates of any of the 24 ABMS member boards who meet the eligibility requirements.*	**Part III:** Changes to the ABPM MOC exam are not being considered at this time.
	Part IV[2]: Diplomates must complete two IMP activities. One of the activities must be completed through a preventive medicine specialty or subspecialty society (ACOEM, ACPM, AMIA, AsMA, or UHMS).	**Part IV[3-4]:** Partnering with specialty societies to design quality and performance improvement activities for diplomates with population-based clinical focus (i.e., public health).
Psychiatry and Neurology (ABPN) abpn.com	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. ABPN is developing MOC exams with committees of clinically active diplomates to ensure relevance to practice. ABPN is also enabling diplomates with multiple certificates to take all of their MOC exams at once and for a reduced fee. Grace period so that diplomates can retake the exam.	**Part III:** ABPN is implementing a Part III pilot program through 2021 to allow physicians who read lifelong learning articles and demonstrate learning by high performance on the questions accompanying the article, to earn exemption from the 10-year MOC high-stakes exam.
	Part IV[2]: Diplomates satisfy the IMP requirement by completing one of the following: 1) Clinical Module: Review of one's own patient charts on a specific topic (diagnosis, types of treatment, etc.). 2) Feedback Module: Obtain personal feedback from either peers or patients regarding your own clinical performance using questionnaires or surveys.	**Part IV[3-4]:** ABPN is allowing Part IV credit for IMP and patient safety activities diplomates complete in their own institutions and professional societies, and those completed to fulfill state licensure requirements. Diplomates participating in registries, such as those being developed by the American Academy of Neurology and the American Psychiatric Association, can have 8 hours of required self-assessment CME waived.

Radiology (ABR) theabr.org	**Part III:** Computer-based secure modular exam administered at a proctored test center. Diplomates must pass the exam once every 10 years.	**Part III:** An Online Longitudinal Assessment (OLA) model replaces the 10-year traditional exam. OLA includes modern and more relevant adult learning concepts to provide psychometrically valid sampling of the diplomate's knowledge. Diplomates must create a practice profile of the subspecialty areas that most closely fit what they do in practice, as they do now for the modular exams. Diplomates will receive weekly emails with links to questions relevant to their registered practice profile. Questions may be answered singly or, for a reasonable time, in small batches, in a limited amount of time. Diplomates will learn immediately whether they answered correctly or not and will be presented with the question's rationale, a critique of the answers, and brief educational material. Those who answer questions incorrectly will receive future questions on the same topic to gauge whether they have learned the material.
	Part IV[2]: Diplomates must complete at least one practice QI project or participatory quality improvement activity in the previous 3 years at each MOC annual review. A project or activity may be conducted repeatedly or continuously to meet Part IV requirements.	**Part IV[3-4]:** ABR is automating data feeds from verified sources to minimize physician data reporting. ABR is also providing a template and education about QI to diplomates with solo or group projects.
Surgery (ABS) absurgery.org	**Part III:** Computer-based secure exam administered at a proctored test center. Diplomates must pass the exam once every 10 years. Transparent exam content, with outlines, available on the ABS website and regularly updated. The ABS is coordinating with the American College of Surgeons and other organizations to ensure available study materials align with exam content.	**Part III:** In 2018, the ABS began offering shorter, more frequent, open-book, modular, lower-stakes assessments required every 2 years in place of the high-stakes exam. The new assessment is being introduced for general surgery, with other ABS specialties launching over the next few years: • Diplomates will select from four practice-related topics: general surgery, abdomen, alimentary tract, or breast;

		• More topics based on feedback from diplomates and surgical societies are being planned; • Diplomates can take the assessment through their own computer at a time and place of their choosing within the assessment window; • 40 questions total (20 core surgery, 20 practice-related; • Open book (topics and references provided in advance); • Individual questions are untimed (with 2 weeks to complete); and • Immediate feedback and results (two opportunities to answer a question correctly).
	Part IV[2]: The ABS allows ongoing participation in a local, regional or national outcomes registry or quality assessment program, either individually or through the diplomate's institution. Diplomates must describe how they are meeting this requirement—no patient data is collected. The ABS audits a percentage of submitted forms each year.	**Part IV:** The ABS allows multiple options for registry participation, including individualized registries, to meet IMP requirements.
Thoracic Surgery (ABTS) abts.org	**Part III:** Remote, secure, computer-based exams can be taken any time 24/7 that the physician chooses during the assigned 2-month period (September-October) from their home or office. Diplomates must pass the exam once every 10 years. Modular exam, based on specialty, and presented in a self-assessment format with critiques and resources made available to diplomates.	**Part III:** The ABTS developed a web-based self-assessment tool (SESATS) that includes all exam material, instant access to questions, critiques, abstracts and references.
	Part IV[2]: ABTS diplomates must complete at least one practice quality improvement project within 2 years, prior to their 5-year and 10-year milestones. There are several pathways by which diplomates may meet these requirements: individual, group or institutional.	**Part IV[3-4]:**
Urology (ABU) abu.org	**Part III:** Computer-based secure exam administered at a proctored test center once a year (October). Diplomates must pass the exam once every 10 years. Clinical management emphasized on the exam. Questions are derived from the American Urological Association (AUA) Self-Assessment Study Program booklets	**Part III:** The knowledge assessment portion of the lifelong learning program will not be used as a primary single metric that influences certificate status but rather to help the diplomate to identify those areas of strength versus weakness in their medical knowledge (knowledge that is pertinent to their practice). To that end ABU will continue the

	from the past five years, AUA Guidelines, and AUA Updates. Diplomates required to take the 40-question core module on general urology, and choose one of four 35-question content specific modules. ABU provides increased feedback to reinforce areas of knowledge deficiency.	modular format for the lifelong learning knowledge assessment. The knowledge assessment will be based on criterion referencing, thus allowing the identification of two groups, those who unconditionally pass the knowledge assessment and those who are given a conditional pass. The group getting a conditional pass will consist of those individuals who score in the band of one standard error of measurement above the pass point down to the lowest score. That group would be required to complete additional CME in the areas where they demonstrate low scores. After completion of the designated CME activity, they would continue in the lifelong learning process and the condition of their pass would be lifted.
	Part IV[2]: Completion of Practice Assessment Protocols. ABU uses diplomate practice logs and diplomate billing code information to identify areas for potential performance or QI.	**Part I[3-4]:** ABU allows credit for registry participation (i.e., participation in the MUSIC registry in Michigan, and the AUA AQUA registry). Another avenue to receive credit is participation in the ABMS multi-specialty portfolio program (this is more likely to be used by Diplomates who are part of a large health system, e.g. Kaiser, or those in academic practices).

* The information in this table is sourced from ABMS Member Board websites and is current as of January 15, 2019.

[1] Utilizing CertLink™, an ABMS web-based platform that leverages smart mobile technology to support the design, delivery, and evaluation of longitudinal assessment programs, some of which launched in 2017-2018. More information is available at: abms.org/news-events/american-board-of-medical-specialties-announces-development-of-new-web-based-platform/ (accessed 1-2-19).

[2] Participates in the ABMS Portfolio Program.

[3] Improving alignment between national value-based reporting requirements and continuing certification programs.

[4]Aligning MOC activities with physician well-being, public health initiatives, and national quality strategies via the ABMS MOC Directory.

APPENDIX G

Alternative Pathways to Board Recertification*

Recertification Program	Recertification Requirements	Exceptions
American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) The ABMS (abms.org), founded in 1933 as the Federation of Independent Specialty Boards, bases its certification on collective standards of training, experience, and ethical behavior. Each of the ABMS member boards develops its specific standards for certification, and together they certify more than 880,000 allopathic and osteopathic physicians in 40 primary specialties and 85 subspecialties. The wide-scale use of ABMS board certification is reflected in both training and delivery systems, and based on core competencies developed and adopted by the ABMS and the Accreditation Council for Graduate Medical Education (ACGME): practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism.	The continuing board certification requirements differ among the ABMS member boards; however, at minimum, to be eligible for recertification, diplomates must meet the standards in each of these areas: • Part I: Professionalism and Professional Standing (maintain a valid, unrestricted medical license) • Part II: Lifelong Learning and Self-Assessment (complete a minimum of 25 continuing medical education [CME] credits per year [averaged over 2 to 5 years]) • Part III: Assessment of Knowledge, Judgment, and Skills (pass a secure examination to assess cognitive skills at periodic intervals) • Part IV: Improvement in Medical Practice (participate in practice assessment and quality improvement every 2 to 5 years)	Diplomates with lifetime (grandfathered) certification are not required to participate in the ABMS MOC program.
American Osteopathic Association (AOA) Osteopathic Continuous Certification (OCC) The AOA Bureau of Osteopathic Specialists (AOA-BOS) (osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/bos-history.aspx) was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. Today, 18 AOA-BOS specialty certifying boards offer osteopathic physicians the option to earn board certification and recertification in numerous specialties and subspecialties. As of December 31, 2007, 31,762 physicians were certified by the AOA, and 1,357 diplomates completed OCC.	Osteopathic physicians who hold a time-limited certificate are required to participate in the following five components of OCC to maintain osteopathic board certification: • Component 1 - Active Licensure (maintain a valid, active license to practice medicine in one of the 50 states, and adhere to the AOA's Code of Ethics) • Component 2 – Life Long Learning/CME (fulfill a minimum of 120 - 150 hours of CME credit during each 3-year CME cycle) • Component 3 - Cognitive Assessment (pass one, or more, proctored examinations to assess specialty medical knowledge and core competencies in the provision of health care) • Component 4 - Practice Performance Assessment and Improvement (engage in continuous quality improvement through comparison of personal practice performance measured against national standards for the physician's medical specialty) • Component 5 - Continuous AOA Membership	Osteopathic physicians who hold non-time-limited (non-expiring) certificates are not required to participate in OCC. To maintain their certification, they must continue to meet licensure, membership, and CME requirements (120-150 credits every three-year CME cycle, 30 of which are in AOA CME Category 1A).

American Board of Physician Specialties (ABPS) ABPS (abpsus.org) is a multi-specialty board certifying body of the American Association of Physician Specialists (AAPS), Inc., which was founded by surgeons in 1950. The member boards of the ABPS offer specialty certification examinations for qualified allopathic and osteopathic physicians. The ABPS is governed by a board of directors and chief executive officer, who oversee eligibility requirements and testing standards. The 12-member boards of the ABPS offer certification in 18 specialties. To achieve recertification, an ABPS board certified physician must participate in a regular schedule of maintenance and enhancement of competency (MAEC) in his or her specialty.	The eligibility requirements for recertification differ among the ABPS member boards; however, at minimum, the boards require that physicians meet the following MAEC requirements every 8 years: • Maintain a full and unrestricted license in every state where he or she practices • Complete a non-remedial medical ethics program • Complete 400 CME hours during the 8-year cycle, and must have had at least an average of 25 CME hours per year in his or her specialty (also, an average of 50 questions of self-assessment CME examinations [as approved by the physician's certifying board] must be completed annually until the final year of the 8-year cycle.) • Pass a 100-question, securely administered, written examination in the final year of the 8-year cycle	Physician recertification through the ABMS and the AOA-BOS does not preclude practicing physicians who qualify from seeking recertification through the ABPS. Many of the ABPS Diplomates in leadership positions are dual-certified through the ABPS and either the ABMS or AOA-BOS.
National Board of Physicians and Surgeons (NBPAS) The NBPAS (nbpas.org) offers a two-year recertification program in all current ABMS specialties for physicians (MDs and DOs) who meet its criteria. The NBPAS has more than 6,000 participants, and is working to gain acceptance by hospitals and payers. As of January 1, 2018, 70 hospitals (credentials committees, medical executive committees and/or hospital boards) had voted to accept the NBPAS as an alternative to ABMS recertification.	To be eligible for NBPAS recertification, candidates must meet the following criteria: • Previous certification by ABMS/AOA member board • Valid medical license (hold a valid, unrestricted license to practice medicine in at least one U.S. state; candidates who only hold a license outside of the U.S. must provide evidence of an unrestricted license from a valid non-U.S. licensing body) • Submission of CME credits (complete a minimum of 50 hours of CME within the past 24 months; CME must be related to one or more of the specialties in which the candidate is applying; and re-entry for physicians with lapsed certification requires 100 hours of CME within the past 24 months) • Active hospital privileges (for some specialties, i.e., interventional cardiology, electrophysiology, surgical specialties, must have active privileges to practice that specialty in at least one U.S. hospital licensed by a nationally recognized credentialing organization with authority from the Centers for Medicare & Medicaid Services (CMS), i.e., The Joint Commission, Healthcare Facilities Accreditation Program, and DNV [Det Norske Veritas] Healthcare) • Medical staff appointment/membership (a candidate who has had their medical staff appointment/ membership or clinical privileges in the specialty for which they are seeking certification involuntarily revoked and not reinstated, must have subsequently maintained medical staff appointment/membership or clinical privileges for at least 24 months in	Physicians in or within two years of training are exempt from CME requirements. Physicians who are grandfathered and whose certification has not, by definition, expired must have completed at least 50 hours (not 100 hours) of CME in the past 24 months.

	another U.S. hospital licensed by a nationally recognized credentialing organization with authority from CMS [as listed above])	
American Board of Facial Plastic and Reconstructive Surgery (ABFPRS) The ABFPRS (abfprs.org) was established in 1986 to improve the quality of medical and surgical treatment available to the public by examining for professional expertise in facial plastic and reconstructive surgery. Since January 2001, the certificates issued by the ABFPRS been valid for 10 years only. Diplomates who were certified since then and who want to maintain their certification must participate in the ABFPRS Maintenance of Certification in Facial Plastic and Reconstructive Surgery® (MOC in FPRS®) program. As of January 2019, the total number of active ABFPRS diplomates was 1,353 and of these 333 diplomates have completed the MOC in FPRS requirements.	ABFPRS recertification has four components. To be eligible for recertification, diplomates must meet standards in each of these four areas: 1. Professional Standing: • Previous certification by the ABFPRS, American Board of Otolaryngology, American Board of Plastic Surgery or Royal College of Physicians and Surgeons of Canada in otolaryngology/head-and-neck surgery or plastic surgery • An unrestricted U.S. or Canadian medical license • Acceptable responses to a questionnaire regarding past or pending adverse actions • Satisfactory status with the Federation of State Medical Boards and the National Practitioners Data Bank • Documentation of privileges to practice facial plastic surgery in an accredited institution(s) or facility • Compliance with the ABFPRS Code of Ethics 2. CME: Complete 50 hours of CME during the 2 years preceding recertification 3. Cognitive Expertise: Pass proctored written and oral examinations 4. Practice Performance: Submit a 12-month sequential operative log of eligible procedures performed during the year preceding submission of an application, with a minimum of 50 procedures, and operative reports for the last 35 sequential cases on the operative log	
American Board of Cosmetic Surgery (ABCS) The ABCS (americanboardcosmeticsurgery.org), established in 1979, offers board certification exclusively in cosmetic surgery to qualifying surgeons. As of January 4, 2019, approximately 350 surgeons were certified by the ABCS. ABCS certification is valid for 10 years. All ABCS diplomates must be re-examined and complete all recertification requirements prior to completion of their 10th year of certification.	To be eligible for recertification, a surgeon must: • Hold at least one board certificate, recognized by the ABMS or the equivalent from the AOA, Royal College of Physicians and Surgeons of Canada, or American Board of Oral & Maxillofacial Surgery, in one of nine medical specialties related to cosmetic surgery • Maintain an unrestricted medical license • Complete 75 hours of CME during the immediate 3-years preceding recertification • Pass a comprehensive written exam • Demonstrate a high level of patient satisfaction based on surveys	

* The information in this table is sourced from the noted recertification program websites and is current as of January 15, 2019.

APPENDIX H

Recommended Changes to HOD Policies Related to Maintenance of Certification and Osteopathic Continuous Certification

H-275.924, ~~Maintenance of Certification~~ Continuing Board Certification

AMA Principles on ~~Maintenance of Certification~~ Continuing Board Certification (~~MOC~~CBC)

1. Changes in specialty-board certification requirements for ~~MOC~~CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in ~~MOC~~CBC must be reasonable and take into consideration the time needed to develop the proper ~~MOC~~CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the ~~MOC~~CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the ~~MOC~~CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. ~~MOC~~CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of ~~MOC~~CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for ~~MOC~~CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of ~~MOC~~CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with ~~MOC~~CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): “Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for ~~MOC~~CBC Part II. The content of CME and self-assessment programs receiving credit for ~~MOC~~CBC will be relevant to advances within the diplomate’s scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit”, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A).”
10. In relation to ~~MOC~~CBC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. ~~MOC~~CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to ~~MOC~~CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. ~~MOC~~CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The ~~MOC~~CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. ~~MOC~~CBC should be used as a tool for continuous improvement.
15. The ~~MOC~~CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing ~~MOC~~CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. ~~MOC~~CBC activities and measurement should be relevant to clinical practice.
19. The ~~MOC~~CBC process should be reflective of and consistent with the cost of development and administration of the ~~MOC~~CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in ~~MOC~~CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in ~~MOC~~CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for ~~Maintenance of Certification~~Continuing Board Certification from their specialty boards. Value in ~~MOC~~CBC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of ~~MOC~~CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both ~~MOC~~CBC content and processes.
(CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16 Modified: Res. 307, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 319, A-17 Reaffirmed in lieu of: Res. 322, A-17 Modified: Res. 953, I-17)"

D-275.954, ~~Maintenance of Certification and Osteopathic Continuous Certification~~ Continuing Board Certification
Our AMA will:
1. Continue to monitor the evolution of ~~Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC)~~Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for ~~MOC~~CBC, and prepare a yearly report to the House of Delegates regarding the ~~MOC and OCC~~CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review ~~MOC and OCC~~CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of ~~MOC~~CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and ~~MOC~~CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and ~~MOC~~CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of ~~MOC~~CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that ~~MOC~~CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that ~~MOC~~CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from ~~MOC~~CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting ~~MOC~~CBC and certifying examinations.
10. Encourage the ABMS to ensure that ~~MOC~~CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of ~~MOC~~CBC on physicians with multiple board certifications, particularly to ensure that ~~MOC~~CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for ~~MOC~~CBC; (b) support ABMS member board activities in facilitating the use of ~~MOC~~CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet ~~MOC~~CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether ~~MOC~~CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from ~~MOC~~CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping ~~MOC and OCC~~CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and ~~MOC~~CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of ~~MOC~~CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant ~~MOC~~CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the ~~MOC~~CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the ~~MOC~~CBC process be required to participate in ~~MOC~~CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of ~~MOC~~CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's ~~MOC~~CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the ~~MOC~~CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on ~~Maintenance of Certification~~ Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on ~~maintenance of certification~~ continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff

bylaws while advocating that ~~Maintenance of Certification~~ Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that ~~maintenance of certification~~ continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for ~~MOC~~CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.
38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.
39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education s annual report on maintenance of certification at the 2019 Annual Meeting.
(CME Rep. 2, I-15 Appended: Res. 911, I-15 Appended: Res. 309, A-16 Appended: CME Rep. 02, A-16 Appended: Res. 307, I-16 Appended: Res. 310, I-16 Modified: CME Rep. 02, A-17 Reaffirmed: Res. 316, A-17 Reaffirmed in lieu of: Res. 322, A-17 Appended: CME Rep. 02, A-18 Appended: Res. 320, A-18 Appended: Res. 957, I-18)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-19

Subject:	Standardizing the Residency Match System and Timeline (CME Report 6-A-17)
Presented by:	Carol Berkowitz, MD, Chair
Referred to:	Reference Committee C (Nicole Riddle, MD, Chair)

INTRODUCTION

Council on Medical Education Report 6-A-17 recommended, in part, that our American Medical Association (AMA):

- Encourage the Association of University Professors of Ophthalmology, the American Urological Association and other appropriate stakeholders to move ophthalmology and urology, which have early matches, into the National Resident Matching Program (NRMP); and

- Encourage the NRMP to create a sequential match process for those specialties that require a preliminary year of training, thus allowing a match to a PGY-2 position to be followed later by a second match to a PGY-1 position, which would reduce applicants' expenses for applications and travel.

At the 2017 Annual Meeting, testimony before Reference Committee C and the House of Delegates reflected almost evenly mixed testimony on this report. Representatives of the affected disciplines (ophthalmology and urology) argued that the current match system works well, provides savings in travel costs, and minimizes inconvenience. In addition, those who are unsuccessful in the ophthalmology or urology match can pursue a position in the NRMP match. It was also noted that it is impossible to guarantee that the complex match algorithm run by the NRMP could accommodate a sequential match. Others argued in favor of the report's adoption, to level the playing field for all medical students; simplify couples' matching (particularly for couples who are in separate matches); and heighten the opportunity for students to be exposed (during their fourth-year rotations) to fields that might be rewarding choices. The HOD referred recommendations 2 and 3, which are shown above; recommendation 1 was adopted (D-310.977 [16], "National Resident Matching Program Reform").

This report by the Council on Medical Education includes: 1) a brief summary of CME Report 6-A-17; 2) a description of recent changes in matching status for urology and ophthalmology specialties; 3) an accounting of the number of specialties and programs that currently require applicants to simultaneously match into a preliminary year of training and a second year of training that could participate in a sequential match; and 4) the results of discussions with the NRMP regarding a sequential match.

BACKGROUND

The specialties of ophthalmology and urology have had their own match programs for many years, primarily because both specialties require a preliminary year of training. Typically, for ophthalmology, residents spend that first postgraduate year, or PGY-1, in a transitional or internal medicine program; for urology, the PGY-1 year is spent in general surgery. The matches for ophthalmology and urology occur in January (earlier in the academic year than for specialties that secure matches through the NRMP), which allows applicants successfully matched into ophthalmology or urology PGY-2 positions to then attempt to match into PGY-1 positions in the NRMP. For some applicants, this system can be advantageous.

For example, successful applicants to early match programs will have resolved some or all of the guesswork involved in finding a PGY-1 position. Receiving interview offers for a PGY-2 position in a particular geographic area can help in application and interview strategies for a PGY-1 position, and once the match has occurred, the applicant can submit a tailored rank order list for the PGY-1 position. Potentially unsuccessful candidates who do not receive interview offers from early match programs will still have time to apply to programs in other specialties.

The limitations of the early match process, however, include additional planning, a drawn-out application and interview season, and substantial financial costs for the applicant (especially for ophthalmology applicants), without the advantages available through the NRMP. Since 1988 the NRMP has had the capability to match applicants simultaneously into PGY-1 and PGY-2 positions, by creating a supplemental rank order list. This process is used by many applicants to programs that have advanced positions, such as radiology, which requires a preliminary PGY-1 position. Furthermore, the NRMP allows two applicants to link their rank order lists in such a way as to maximize their opportunity to match into programs in the same geographic area—the so-called "couples match." Neither of these more sophisticated matching processes is available in the early match programs. Finally, the NRMP offers far more detailed match analyses and statistics, which can assist applicants and their advisors in crafting match strategy.

The two specialties that hold early matches are the primary beneficiaries of the current system. Ophthalmology and urology are able to control their own matches and peruse, interview, and claim future residents before other specialties. In addition, applicant match fees generate funds through which the specialties can create educational resources.

Council on Medical Education Report 6-A-17 concluded that if the NRMP were able to hold a sequential match, the advantages to applicants of participating in two matches, i.e., being able to reduce the number of applications sent and limit travel for interviews for a preliminary year position, could be extended to applicants in such specialties that require a preliminary year.

CHANGES IN TRAINING LENGTH AND REQUIREMENTS

Both ophthalmology and urology specialties have proposed revisions to the length of training required in their respective specialties, which would affect the necessity for two separate matches.

Ophthalmology

Currently, Accreditation Council for Graduate Medical Education (ACGME) program requirements for ophthalmology state that the length of the training program must be 36 months, and that prior to appointment to a program, residents must have completed a postgraduate clinical year in an ACGME-accredited program (or a program located and accredited in Canada) in

emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery, or transitional year. This has been the established length and sequence of ophthalmology training for many years.

In 2013, the American Academy of Ophthalmology and the Association of University Professors of Ophthalmology (AUPO) identified a need to restructure the PGY-1 year.[1] In August 2018, the ACGME review committee for ophthalmology proposed revisions to the program requirements, which were accepted by the ACGME Board of Directors in February 2019. The revisions to ophthalmology program requirements regarding the PGY-1 year go into effect July 2021.[2]

Education in ophthalmology will then become 48 months in length, in one of two formats: an integrated format in which all 48 months are under the authority and direction of the ophthalmology program director, or in a joint/preliminary format, in which a preliminary year precedes 36 months of education in an ophthalmology program. In the latter case, the preliminary year will take place in the same institution that sponsors the ophthalmology program, and the ophthalmology program director will have input into the PGY-1 education. Regardless of format, all residents must have three months of ophthalmology education during the PGY-1 year.[2]

Recognizing that these revisions may require significant changes for existing programs, the ACGME will not administer citations to programs for not having an integrated or joint/preliminary program and related PGY-1 requirements until after July 2023; furthermore, programs that are unable to establish either format may request an exception from the Review Committee.[3]

Once these requirements are in place, the need for applicants to use the NRMP to match into PGY-1 positions after they have matched into an ophthalmology program using the San Francisco Match (SF Match, the matching service used by ophthalmology programs, owned by the AUPO) may be reduced, at least for those applicants matching into integrated programs. While the review committee notes that a “number” of programs are currently in the joint/preliminary format, an exact count is not known. Given the coordination and negotiation that ophthalmology programs will have to undertake with other training programs (such as transitional year programs) to ensure that there will be PGY-1 positions at the sponsoring institution with three months of ophthalmology experience, it may be some time before all programs are fully compliant with these requirements. If all programs were to become fully integrated, the need for a separate match that takes place before or outside of the NRMP’s Main Residency Match would seem to be obviated. As an example, the specialties of otolaryngology and neurosurgery previously participated in the San Francisco Match, but joined the NRMP once the decision was made to fully integrate the PGY-1 year. However, ophthalmology’s history with the SF Match, and the revenue it generates for the AUPO, may lead the organization to continue to operate the match separately.

Urology

In October 2017, the ACGME review committee for urology proposed, as part of the decennial major revision for urology training, to change the accredited training length from 48 months to 60 months by encompassing the PGY-1 year. These revisions were accepted by the ACGME Board in June 2018 and go into effect in July 2019.[4] Previously, residents who entered urology in the PGY-2 year spent the PGY-1 year in a general surgery program. When the revisions take effect, residents will no longer need to use the NRMP to match into the general surgery year. Senior medical students will use the Electronic Residency Application Service (ERAS) to apply to urology programs only (no longer applying to surgical programs as well) and will continue to use the match service run by the American Urological Association (AUA) to match directly into a urology program. Given the urology profession’s satisfaction in controlling the match, as well the perceived

benefits of holding the match earlier in the year than the NRMP match, it is unlikely that urology will join the NRMP at this time.[5]

SPECIALTIES WITH TWO MATCHES

In the NRMP's 2018 Main Residency Match, there were 11 specialties with PGY-2 (advanced) positions, as shown in the table below.[6]

Specialty	No. of programs	No. of positions
Anesthesiology	75	447
Child neurology	7	8
Dermatology	122	426
Interventional radiology (integrated)	51	98
Neurodevelopmental disabilities	3	4
Neurology	55	287
Nuclear medicine	2	3
Physical medicine & rehabilitation	61	281
Radiation oncology	85	177
Radiology-diagnostic	171	944
Radiology-nuclear medicine	3	3
Total	*635*	*2,678*

Of the 4,780 applicants ranking at least one PGY-2 position combined with a PGY-1 position, 2,244 individuals matched to both. Many of the 4,780 applicants also ranked categorical positions as well; most of the 2,536 who did not match into both a PGY-1 and PGY-2 position were successfully matched to another position.[7]

The proportion of programs with advanced positions and the proportion of advanced positions offered have decreased over time. In the 2008 Main Residency Match, 14.5 percent of all participating programs offered PGY-2 positions, and PGY-2 positions made up 11.3 percent of all positions offered.[8] In 2018, those percentages had declined to 11.9 percent and 8.1 percent, respectively.[6]

DISCUSSIONS WITH THE NRMP

The NRMP has previously considered a two-phased Main Residency Match for the purpose of eliminating the "Scramble" that occurred during Match Week. Although applicants, medical schools, and residency program directors liked the idea of a two-phased Match, they did not like the schedule. Medical schools did not want the Match to occur earlier than March because it would further erode the fourth-year curriculum, and program directors did not want a final Match Day to occur later than the month of March because of difficulties on-boarding new residents. A second Match designed to fill preliminary positions would be difficult to implement not just because of scheduling, but also because the significant cost could not be justified for a relatively small number of positions. The majority of applicants are able to match simultaneously to PGY-1 and PGY-2 positions. Applicants ranking PGY-2 positions in advanced programs can create and attach a supplemental rank order list of preliminary programs to each advanced program. Also, many programs with advanced positions have agreements with programs with preliminary positions at the same institution to coordinate interviewing applicants at the same time and to create joint advanced/preliminary arrangements so that applicants can match simultaneously into a full course of training.[9]

The NRMP also has fielded questions regarding Match flexibility and scheduling for applicants who have graduated from medical school "off-cycle," a potential result of participating in a competency-based medical school educational program. The NRMP's All In Policy states that a residency program that registers for the Main Residency Match must attempt to fill all of its positions through the Match. Offering a position outside the Match makes the program ineligible for the Match, unless the program has been granted an exception. To date, the NRMP Board of Directors has not granted an exception for competency-based curricula, although it is reviewing an exception request submitted by the Education in Pediatrics Across the Continuum (EPAC) Project. It is important to note, however, that if a program has a position that becomes available after September, and training can begin before February 1, that position can be filled off-cycle without jeopardizing the program's adherence to the All In Policy.

CURRENT AMA POLICY

AMA policies related to this topic are listed in the Appendix.

SUMMARY AND RECOMMENDATIONS

Recently proposed revisions to the program requirements for ophthalmology and urology have changed the dynamics of the early match. The concerns expressed by those applicants who needed to participate in two separate matches for a urology position have been alleviated, as the match run by the AUA will now include PGY-1 positions. Those who do not successfully match into a urology program will still have the opportunity to apply to, interview for, and rank a program in the NRMP. A somewhat similar situation exists for students applying to ophthalmology programs. Even though the new integrated and joint/preliminary format changes more closely incorporate the PGY-1 year, the specialty's desire to control the match process suggests that, at least in the near future, there will continue to be two matches. However, applicants entering the ophthalmology and urology matches do not have the opportunity to fully participate in the NRMP "couples match," nor do they benefit from insight provided by the sophisticated data analysis and reports prepared by the NRMP. Additionally, preservation of this two-step match process may reduce applicants' exposure (during their fourth-year rotations) to fields that they might have otherwise enjoyed as a result of the earlier commitment to registering for the ophthalmology or urology match.

While the NRMP has investigated the possibility of a sequential match, which could reduce application and interview costs for students applying to programs with advanced positions, at this time it has concluded that the amount of coordination, cooperation, and costs involved were not justified given the relatively small number of students affected. However, the NRMP is exploring if it is possible to provide exceptions to programs that wish to accept students who graduate from competency-based medical education programs at off-cycle times.

The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our AMA encourage appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions. (Directive to Take Action)

2. That our AMA work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) to create local PGY-1 positions that will enable coordinated applications and interviews for medical students. (Directive to Take Action)

3. That our AMA encourage the NRMP to design a process that will allow competency-based student graduation and off-cycle entry into residency programs. (Directive to Take Action)

4. That our AMA encourage the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, and to ensure that all applicants have access to robust, informative statistics to assist in decision-making. (Directive to Take Action)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

D-310.977, "National Resident Matching Program Reform"

Our AMA … (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including supplication timelines and requirements; (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant; … (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies.

H-310.910, "Preliminary Year Program Placement"

Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

D-310.958, "Fellowship Application Reform"

Our AMA will (1.a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training.

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REPORT 4 OF THE COUNCIL ON MEDICAL EDUCATION (A-19)
Augmented Intelligence in Medical Education (Resolution 317-A-18)
(Reference Committee C)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting of the American Medical Association (AMA), delegates adopted Policy H-480.940, "Augmented Intelligence in Health Care," which established the AMA's first official policy with respect to augmented intelligence (AI). Among other recommendations, the report called on the AMA to "encourage 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."

Also during the 2018 Annual Meeting, Resolution 317-A-18, "Emerging Technologies (Robotics and AI) in Medical School Education," was referred. This resolution called on the AMA to (1) encourage medical schools to evaluate and update as appropriate their curriculum to increase students' exposure to emerging technologies, in particular those related to robotics and artificial intelligence; 2) encourage medical schools to provide student access to computational resources like cloud computing services; 3) reaffirm Policy H-480.988, which urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and 4) reaffirm Opinion 1.2.11 of the AMA Code of Medical Ethics and Policy H-480.996, which state the guidelines for the ethical development of medical technology and innovation in health care.

This report summarizes existing AMA policy related to AI; provides definitions of related terms; reviews current efforts related to AI in medical education; and provides recommendations for consideration by the AMA House of Delegates.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-19

Subject: Augmented Intelligence in Medical Education (Resolution 317-A-18)

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting of the American Medical Association (AMA), the AMA House of Delegates (HOD) adopted Policy H-480.940, "Augmented Intelligence in Health Care," which established the AMA's first official policy with respect to augmented intelligence (AI). Among other recommendations, the report called on the AMA to "encourage 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."[1]

Also during the 2018 Annual Meeting, Resolution 317-A-18, "Emerging Technologies (Robotics and AI) in Medical School Education," introduced by the Maryland Delegation, was referred for further study. This resolution called on the AMA to (1) encourage medical schools to evaluate and update as appropriate their curriculum to increase students' exposure to emerging technologies, in particular those related to robotics and artificial intelligence; 2) encourage medical schools to provide student access to computational resources like cloud computing services; 3) reaffirm Policy H-480.988, which urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and 4) reaffirm Opinion 1.2.11 of the AMA Code of Ethics and Policy H-480.996, which state the guidelines for the ethical development of medical technology and innovation in health care. Testimony on this item in Reference Committee C was mostly supportive, and noted that medical students will need access to new types of technology to be better prepared for practice. The need for continued ethical guidance in this area also was referenced. Testimony in opposition argued that the appropriate place for instruction in these new technologies should be at the graduate medical education (GME), rather than undergraduate medical education (UME) level, as many of these solutions are specialty specific. In light of the Council on Medical Education's planned report to the HOD regarding AI across the medical education continuum at the 2019 Annual Meeting, Resolution 317-A-18 was referred for inclusion in this report.

DEFINITION OF ARTIFICIAL AND AUGMENTED INTELLIGENCE

The AMA's Council on Long Range Planning and Development (CLRPD) defines artificial intelligence as "the ability of a computer to complete tasks in a manner typically associated with a rational human being—a quality that enables an entity to function appropriately and with foresight in its environment. True [artificial intelligence] is widely regarded as a program or algorithm that can beat the Turing Test, which states that an artificial intelligence must be able to exhibit intelligent behavior that is indistinguishable from that of a human."[2] Augmented intelligence,

meanwhile, is "an alternative conceptualization that focuses on [artificial intelligence's] assistive role, emphasizing the fact that its design enhances human intelligence rather than replaces it."[2]

In its report that led to Policy H-480.940, the Board of Trustees further parsed these two related, but distinct, terms: "Artificial intelligence constitutes a host of computational methods that produce systems that perform tasks normally requiring human intelligence. These computational methods include, but are not limited to, machine image recognition, natural language processing, and machine learning. However, in health care a more appropriate term is 'augmented intelligence,' reflecting the enhanced capabilities of human clinical decision making when coupled with these computational methods and systems."[1]

Examples of AI methods used in medicine include, but are not limited to, machine learning, deep learning, neural networks, and natural language processing. Applications include, but are not limited to, clinical decision support tools, diagnostic support tools, virtual reality, augmented reality, simulation, gamification, and wearables that contribute data to physician decision-making. These technologies can be understood to comprise areas of cognition (such as algorithms), workflow (guidance regarding prioritization), quality (validation of algorithms), and monitoring (peer review for machine learning).

THE NEED FOR POLICY RELATED TO ARTIFICIAL AND AUGMENTED INTELLIGENCE

Almost a decade ago, Peter Densen wrote:

> It is estimated that the doubling time of medical knowledge in 1950 was 50 years; in 1980, 7 years; and in 2010, 3.5 years. In 2020 it is projected to be 0.2 years—just 73 days. Students who began medical school in the autumn of 2010 will experience approximately three doublings in knowledge by the time they complete the minimum length of training (7 years) needed to practice medicine. Students who graduate in 2020 will experience four doublings in knowledge. What was learned in the first 3 years of medical school will be just 6% of what is known at the end of the decade from 2010 to 2020. Knowledge is expanding faster than our ability to assimilate and apply it effectively; and this is as true in education and patient care as it is in research. Clearly, simply adding more material and or time to the curriculum will not be an effective coping strategy—fundamental change has become an imperative.[3]

Since Densen published his predictions, the pace of change in medical education has continued to be a topic of focus and discussion and can be framed as a disruption to traditional instructional methods and timelines. The AMA has long demonstrated a commitment to developing and supporting disruptive advancements in medical education, both autonomously and in partnership with others. This commitment can be seen in the Council on Medical Education's contributions to the 1910 Flexner Report, the establishment of many of the leading U.S. medical education organizations that exist today, the groundbreaking Accelerating Change in Medical Education Consortium, the newly launched Reimagining Residency initiative, and enhanced e-learning content design and delivery. It is therefore appropriate that the AMA now begin work on a body of policy and thoughtful guidance related to AI in medical education, especially as Policy H-480.940, Resolution 317-A-18, and the CLRPD's Primer on Artificial and Augmented Intelligence have clearly demonstrated the urgent need for policy in this area.

DISCUSSION

As with many previously introduced technologies, the potential benefits, risks, and unknowns of incorporating AI into medical education have yet to be fully revealed. The promise of AI in medical education includes the potential for enhanced learning, ultimately resulting in benefit to patients; efficiency gains achieved via a reallocation of physician time; further development of physicians' emotional intelligence skills due to a reduced need to focus on automatable tasks; and enhanced learner evaluations, including the ability to assess competencies prospectively, accurately, and continuously, leading to greater facilitation of independent learning and an elimination of the "stop and test" mindset. Just-in-time assessments and learning interventions may assist with progression through competencies. In the context of the AMA's current focus on health systems science, AI promises to enable more encompassing systems analyses and quality improvement approaches and to introduce computational modeling that may replace cycles of iterative improvements. Additionally, AI in medicine may aid instruction in and delivery of care to rural or otherwise underserved locations.

Concerns, however, also exist, such as the possibility of physician de-skilling as more cognitive tasks are performed by AI; an unintentional reinforcement of health disparities,[4] both in terms of patient health outcomes and for clinicians practicing in less resourced clinical environments; the potential loss of physician humanism and further deterioration of physicians' bedside skills; and the risk of overutilization of AI-delivered care, such as the use of technology for the sake of using technology and the risk of adding to, rather than replacing items in, the curriculum.

Unknowns range from implications for learner wellness to concerns regarding exposure of gaps in faculty knowledge. Incorporation of AI in medical education may streamline learning and clinical workflow, gifting additional time to learners that can be used to focus on patients and self; however, it also has the potential to do the opposite, disrupting and displacing traditional instructional techniques without clear benefits to learners or patients. Other unknowns include the effects of AI on the teaching/modeling of professional judgment; medicolegal and ethical concerns; and rapidly changing regulatory modernization models.

The exposure of gaps in faculty knowledge of AI is already being documented; these gaps may be inhibiting learners who have an active interest in AI applications but lack exposure to knowledgeable faculty to help them understand, access, and apply them. For example, a 2015 publication[5] noted that 30 percent of U.S. medical student survey respondents had interest in clinical informatics, but were not able to identify training opportunities to assist in meeting this desire to learn. These knowledge gaps, however, should not be solely characterized in a negative fashion, as they also present important opportunities for professional development and pave the way for the introduction of new types of instructors into the medical education environment. Gonzalo et al.[6] acknowledge these points, noting the importance of focusing not only on expanding the knowledge base/skill set of current educators, but also of employing a new cohort of educators with skills in new areas. The Council on Medical Education agrees with this characterization and believes that institutional leaders and academic deans must proactively accelerate their inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters.

Investments in AI

Private funding of AI technologies has exploded in recent years. One source estimates that the AI health market will grow to $6.6 billion by 2021 and exceed $10 billion by 2024.[7] Another estimate places AI-driven GDP growth at $15.7 trillion by 2030.[8]

The U.S. House of Representatives' Committee on Oversight and Reform, Subcommittee on Information Technology, has specifically noted that one of the benefits of increased U.S. funding for AI research and development would be the ability to fund more graduate students, which in turn would expand the future U.S. AI workforce. On February 11, 2019, President Donald J. Trump issued an Executive Order on Maintaining American Leadership in Artificial Intelligence, which, acknowledges that "[c]ontinued American leadership in AI is of paramount importance to maintaining the economic and national security of the United States and to shaping the global evolution of AI in a manner consistent with our Nation's values, policies, and priorities," and notes that the United States "must train current and future generations of American workers with the skills to develop and apply AI technologies to prepare them for today's economy and jobs of the future." This training will be achieved through "apprenticeships; skills programs; and education in science, technology, engineering, and mathematics (STEM), with an emphasis on computer science, to ensure that American workers, including Federal workers, are capable of taking full advantage of the opportunities of AI."[9]

Additionally, the Centers for Medicare & Medicaid Services has recently committed to investment in this area and has launched an Artificial Intelligence Health Outcomes Challenge,[10] with the goal of "exploring how to harness AI to predict health outcomes that are important to patients and clinicians, and to enhance care delivery."

AI and Education

At the practical level, it is important to distinguish between AI as a topic of study itself and in the instruction of learners regarding use of existing tools and applications. Furthermore, it is important to acknowledge that educating students and physicians in the practical use of specific AI technologies is not necessarily equivalent to educating students and physicians to understand how the technology works or how to evaluate its applicability, appropriateness, and effectiveness with respect to patient care.

An additional consideration will be the need for learners and physicians to adjust their receptivity to machine-recommended learning or clinical actions. The need for this receptivity may in turn spark a discussion regarding the kind of student who should be recruited to enter the profession. Traditionally, while multiple domains of ability have been valued, a premium has been placed on individual mastery of knowledge. Learners who excel at this type of knowledge, however, may not be the same kind of learners who interact effectively with AI systems. Even if learners are receptive to this type of practice, a rise in learning and practice that is less supervised by human instructors and colleagues and more interactive with non-human technologies may negatively impact patient care if recruits to the profession are not able to maintain patient communication and develop critical evaluation skills.

Recent scholarly work has documented this shift in thinking with respect to the goals of medical education.[11] Newer thinking acknowledges the rapid pace of change and emphasizes the need for physicians to analyze, categorize, contextualize, seek, find, and evaluate data and place these data in clinical context, and highlights the position that critical reasoning skills are imperative. Wartman and Combs argue that the physician of the future will require a shift in professional identity, which must be embraced early on in medical education.[11] Furthermore, the dawn of precision medicine introduces treatment possibilities that require physicians flexible enough to think beyond established treatment protocols.[11] These changes require parallel changes in the way medical students, residents, fellows, instructors, and practicing physicians are taught and, in turn, teach.

ACCREDITATION AND LICENSURE IMPLICATIONS

Profound changes to established medical educational content, as well as to methods of instruction, necessitate considered and reflective responses from those organizations that focus on accreditation and licensure. Yet the response in this area regarding the implications of AI in medical education has been varied.

The Liaison Committee on Medical Education (LCME) does not specifically address AI, but several of its standards relate to these concepts:

- Standard 4.1, Sufficiency of Faculty, requires that "A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the institution."
- Standard 4.5, Faculty Professional Development, notes, "A medical school and/or its sponsoring institution provides opportunities for professional development to each faculty member in the areas of discipline content, curricular design, program evaluation, student assessment methods, instructional methodology, and research to enhance his or her skills and leadership abilities in these areas."
- Standard 5.4, Sufficiency of Buildings and Equipment, states that "A medical school has, or is assured the use of, buildings and equipment sufficient to achieve its educational, clinical, and research missions."
- Standard 5.6, Clinical Instructional Facilities/Information Resources, requires that "Each hospital or other clinical facility affiliated with a medical school that serves as a major location for required clinical learning experiences has sufficient information resources and instructional facilities for medical student education."
- Standard 5.9, Information Technology Resources/Staff, states that "A medical school must provide access to well-maintained information technology resources sufficient in scope to support its educational and other missions." Further, information technology staff must have "sufficient expertise to fulfill its responsibilities and is responsive to the needs of the medical students, faculty members, and others associated with the institution."
- Standard 6.3, Self-Directed and Life-Long Learning, requires that "The faculty of a medical school ensure that the medical curriculum includes self-directed learning experiences and time for independent study to allow medical students to develop the skills of lifelong learning. Self-directed learning involves medical students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of information sources."

Commission on Osteopathic College Accreditation (COCA) standards are similar:

- Standard 4, Facilities, states that "A COM [college of osteopathic medicine] must have sufficient physical facilities, equipment, and resources for clinical, instructional, research, and technological functions of the COM. These resources must be readily available and accessible across all COM locations to meet its needs, the needs of the students consistent with the approved class size, and to achieve its mission."
- Element 4.3, Information Technology, states that "A COM must ensure access to information technology to support its mission."
- Element 4.4, Learning Resources, requires that "A COM must ensure access to learning resources to support its mission."
- Element 6.7, Self-Directed Learning, requires that "A COM must ensure that the curriculum includes self-directed learning experiences and time for independent study to

allow students to develop skills for lifelong learning. Self-directed learning includes students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of sources of information."

- Element 7.1, Faculty and Staff Resources and Qualifications, states that "At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/ board eligibility. The non-physician faculty must have appropriate qualifications in their fields."
- Element 7.6, Faculty Development, states that "A COM must develop and implement an ongoing needs-based, assessment-driven, faculty development program that is in keeping with the COM's mission."

Licensing exams of the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners do not specifically cover AI.[12] However, the benefits of AI-driven assessments for test preparation and scoring should be further explored, and their potential impacts on costs and student travel/time calculated, in addition to consideration of their inclusion as a topic area in exam content.

The Federation of State Medical Boards (FSMB) recently hosted a conference related to AI and potential impacts on state medical boards. AI can potentially be used to improve physician verification of licensing and credentials. Changes to state medical practice acts and/or model legislation may need to be studied to prepare for AI-driven changes to the practice of medicine.

The Common Program Requirements of the Accreditation Council for Graduate Medical Education (ACGME) do not specifically identify AI, but, as with UME standards from the LCME and COCA, related topics are addressed. Section VI.A.1.b).(2) notes that "access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts." Also, Section VI.A.1.b).(2).(a) notes that "residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations." Perhaps a more natural fit for addressing AI at the GME level could be applied through the pathways framework of the ACGME's Clinical Learning Environment Review (CLER) program, which offers programmatic feedback on the topics of patient safety, health care quality, care transitions, supervision, duty hours and fatigue management/mitigation, and professionalism.[13] Data science could be integrated into pathways for each focus area to support learners' exposure to AI-driven changes in clinical practice. Additionally, individual specialty milestones may be an appropriate location for introduction of artificial/augmented intelligence-driven technologies, many of which are specialty-specific.

None of the member boards of the American Board of Medical Specialties (ABMS) currently require education in AI activities for continuing certification credit. However, five boards[14]—the American Board of Anesthesiology, American Board of Emergency Medicine, American Board of Nuclear Medicine, American Board of Obstetrics and Gynecology, and American Board of Pathology—do accept simulation-based activities for their continuing certification Improvement in Medical Practice requirements (although it is important to note that simulation can be conducted without AI algorithms). In addition, the American Board of Family Medicine has several optional online simulated cases that can count toward meeting Lifelong Learning and Self-Assessment activities. The American Board of Internal Medicine also recognizes some simulation activities for Improvement in Medical Practice through a collaboration with the Accreditation Council for

Continuing Medical Education. Finally, the ABMS has established a new pathway for a subspecialty fellowship in clinical informatics, which is hosted through the American Board of Preventive Medicine.

At the continuing professional development level, AI offers great potential to create precision education via further investments in the adaptive quizzing model, which builds upon current trends in digital portfolios to support responsive assessments and prompts learners to assess specific skills at desired time points. Tailored educational content can be delivered to clinicians at precise moments in time, and AI-driven technologies may better identify the learning needs of busy clinicians than the clinicians themselves.

AI IN MEDICAL EDUCATION: A CURRENT SNAPSHOT

An LCME survey from the 2016-2017 academic year included a question asking institutions to indicate whether computer-based simulators (such as virtual dissection simulation) were used in various disciplines to assist students in learning or reviewing relevant anatomy. Of 145 respondents, 78 indicated simulators were used in gross anatomy, 65 in neuroanatomy/neurosciences, 42 in general surgery, 40 in obstetrics-gynecology, and 26 in surgical subspecialties (respondents could select more than one option).

Multiple forms of AI have been incorporated into medical education training, ranging from basic introductory courses in core data science and algorithm fundamentals to artificial intelligence certificate programs and dual areas of study (MD/DO plus data science, programming, statistics, informatics, or biomedical engineering). The overall extent to which these topics currently have been incorporated into medical education, however, is more difficult to quantify. The following list of examples, while not comprehensive, is meant to highlight the breadth and depth of current/planned utilization of AI in medical education today.

- The Duke Institute for Health Innovation (DIHI), which includes an incubator for health technology innovation, involves medical students in a program that joins clinical, quantitative, and data expertise to create care-enhancement technologies. DIHI students and instructors also work to ensure that AI innovations are not being applied to physicians, but rather developed by and for physicians, and that such innovations support improved models of care and incorporate machine learning into clinical processes. One example of an AI application is early identification of disease progression (such as kidney failure or sepsis).

- The radiology department at the University of Florida has entered into a partnership with a cancer-focused technology firm to develop computer-aided detection (CAD) tools for mammographers. Radiologists, including resident physicians, will be involved in the evaluation of trial technologies, which are intended to flag areas of interest in breast imaging. Residents also will participate in training and validating algorithms.

- The Carle Illinois College of Medicine in Urbana-Champaign, self-described as the first engineering-based college of medicine, seeks to leverage technology by offering a curriculum in which all courses are designed by a scientist, a clinical scientist, and an engineer. Engineering and technology comprise components of all classes, and clinical rounds are completed with both clinical and engineering faculty. The inaugural class will graduate in 2022.

- The Sharon Lund Medical Intelligence and Innovation Institute (MI3) at Children's Hospital of Orange County (CHOC) seeks to cultivate artificial intelligence methodologies and advances in genomic medicine, regenerative medicine, robotics, nanotechnology, and medical applications/devices. The MI3 Summer Internship Program at CHOC offers immersive experiences in genomic and personalized medicine, regenerative medicine and stem cells, nanomedicine, robotics and robotic surgery, artificial intelligence and big data, medical devices and mobile technology, and innovations in health care delivery. This program directly supports the pipeline of clinicians with exposure to AI technologies by inviting high school, college, graduate school, and medical school students to apply.

- The Institute for Innovations in Medical Education at New York University (NYU) Langone Health supports a multidisciplinary team of educators, scientists, informaticians, and software developers who apply informatics to teaching, learning, and assessment. NYU's technology-based Health Care by the Numbers curriculum trains students in the use of "big data" to provide holistic, population health management that improves quality and care coordination.

- The Machine Learning and Healthcare Lab at Johns Hopkins uses statistical machine learning techniques to develop new diagnostic and treatment planning tools that provide reliable inferences to help physicians make individualized care decisions.

- Stanford University's Center for Artificial Intelligence in Medicine and Imaging develops, assesses, and disseminates artificial intelligence systems to benefit patients. Graduates and post-graduates are involved in solving imaging problems using machine learning and other techniques. Stanford also offers a mini-curriculum leading to an Artificial Intelligence Graduate Certificate.

- The Human Diagnosis Project, a partnership of the AMA, the ABMS, and multiple academic centers, is an educational collaboration that sources knowledge via the submission of clinical cases from international medical professionals to create models of care that can be accessed by clinicians and learners worldwide.

- Addressing the paradigm shift in medical education, the University of Texas Dell Medical School does not support a chair of radiology or pathology; rather, leadership has identified and employed a chair of diagnostic medicine.

- The University of Virginia Center for Engineering in Medicine works, as stated in its mission, to generate and translate innovative ideas at the intersection of engineering and medicine. In this collaborative training environment, medical and nursing students are embedded in engineering labs, and engineering students are embedded in clinical environments.

- The College of Artificial Intelligence at the Massachusetts Institute of Technology focuses on interdisciplinary artificial intelligence education in biology, chemistry, history, linguistics, and ethics and is intended to bridge gaps between computer science and other areas.

- The AMA is expanding its educational resources related to AI in medicine to offer an educational module that provides the history, definitions, and components related to AI in health care, as well as a newly developed and continuously evolving website related to augmented intelligence in medicine, which provides resources, insights, and education.

Furthermore, the February 2019 Issue of the AMA's Journal of Ethics was devoted entirely to the ethical implications of AI.

International Attitudes

Steps also are being taken internationally to support the use of AI in medical education. For example, virtual patients are currently being used in medical schools in a number of European countries,[15] and individual schools offer programming in AI, such as the University of Toronto's elective, 14-month Computing for Medicine certificate course.[16]

It is interesting and important to note that attitudes regarding and progress toward use of AI in medical education and clinical treatment vary significantly internationally. Vayena et al. note a recent United Kingdom survey reporting that "63% of the adult population is uncomfortable with allowing personal data to be used to improve healthcare and is unfavorable to artificial intelligence (AI) systems replacing doctors and nurses in tasks they usually perform. Another study, conducted in Germany, found that medical students—the doctors of tomorrow—overwhelmingly buy into the promise of AI to improve medicine (83%) but are more skeptical that it will establish conclusive diagnoses in, for instance, imaging exams (56% disagree). When asked about the prospects of AI, United States decision-makers at healthcare organizations are confident that it will improve medicine, but roughly half of them think it will produce fatal errors, will not work properly, and will not meet currently hyped expectations."[17]

According to a recent survey[18] of general practitioners in the United Kingdom, 68 percent felt that "future technology" would never fully replace human physicians in diagnosis of patients, 61 percent said this technology would never fully replace human physicians when referring to specialists, 61 percent said this technology would never develop personalized treatment plans, and 94 percent said it would never deliver empathetic care. A higher percentage (80 percent) did believe, however, that future technology would be able to replace human physicians to perform documentation.

A 2018 survey of German medical students found that 68 percent were unaware of the specific technologies being used in radiology AI; 56 percent thought AI would not perform well enough to establish a definite diagnosis; 86 percent thought AI would improve radiology, and 83 percent disagreed that AI would replace human radiologists (96.6 percent disagreed that AI would replace human physicians generally). Further, 70.1 percent felt AI should be included in training (interestingly, 20.5 percent mostly disagreed with this statement, and 4.9 percent disagreed entirely).[19]

While European mores may not be translatable to faculty, learners, and patients in the United States, these findings are excellent reminders that different populations—in terms of race, ethnicity, gender, age, socioeconomic background, level of education, and geographic location—not only may have different levels of familiarity and comfort with these new technologies, but also may have different expectations and desires with regard to how or even whether these technologies should be applied. Physicians will need to augment their communication skills to help patients receive the best, personalized treatments that may be enhanced or delivered entirely by AI technologies.

REVIEW OF ADDITIONAL RESEARCH

A paper regarding the biannual Artificial Intelligence in Medicine (AIME) conference in Europe, established in 1985, analyzed the content of papers published in AIME's proceedings; the first six years the topic of knowledge engineering appeared most frequently. Post-2000, machine learning and data mining were covered most frequently. Natural language processing was covered more frequently moving towards 2010, as was research related to ontologies and terminologies.[20]

Kolachalama and Garg note that between 2010 and 2017, relatively little research was published on this topic related to UME and GME. They describe a combined search using the MeSH terms "machine learning" and "graduate medical education" between 2010 and 2017, which resulted in 16 publications, and note, "Detailed review of these papers revealed that none of them were actually focused on ML education for medical professionals."[12]

More research can be found related to virtual reality and augmented reality. A 2016 paper[21] found that learning outcomes improved more for students utilizing an online three-dimensional interactive learning tool (when compared to gross anatomy resources) for neuroanatomy education. Virtual reality and augmented reality have been found to enhance neurosurgery residents' skills while reducing risk to patients, and are also helpful for preoperative planning. Virtual reality and augmented reality also can increase learner engagement and enhance spatial knowledge.[22]

RELEVANT AMA POLICY

At this time, the AMA has limited policy related to AI and medical education. Its most recent policy, H-480.940, "Augmented Intelligence in Health Care," asks our AMA to promote development of thoughtfully designed, high-quality, clinically validated health care AI that 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.

Policy D-295.330, "Update on the Uses of Simulation in Medical Education," encourages ongoing research and assessment regarding the effectiveness of simulation in teaching and assessment, and encourages accrediting bodies to ensure their policies are reflective of appropriate simulation use.

See the Appendix for a full list of relevant policies.

SUMMARY AND RECOMMENDATIONS

As stated in BOT Report 41-A-18, "To reap the benefits for patient care, physicians must have the skills to work comfortably with health care AI. Just as working effectively with EHRs is now part of training for medical students and residents, educating physicians to work effectively with AI systems, or more narrowly, the AI algorithms that can inform clinical care decisions, will be critical to the future of AI in health care." While it is certainly true that physicians and physicians in training must embrace the skills and attitudes that will allow them to care for patients with assistive technologies, it is also true, as noted by Patel et al., that "[a]ll technologies mediate human performance. Technologies, whether they be computer-based or in some other form, transform the ways individuals and groups behave. They do not merely augment, enhance or expedite performance, although a given technology may do all of these things. The difference is not one of quantitative change, but one that is qualitative in nature. Technology, tools, and artifacts not only enhance people's ability to perform tasks but also change the way they perform tasks." [23]

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 317-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards. (Directive to Take Action)

2. That our AMA encourage medical specialty societies and boards to consider production of specialty-specific educational modules related to AI. (Directive to Take Action)

3. That our AMA encourage research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes. (Directive to Take Action)

4. That our AMA encourage institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules. (Directive to Take Action)

5. That our AMA encourage stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems. (Directive to Take Action)

6. That our AMA encourage enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients. (Directive to Take Action)

7. That our AMA encourage institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI. (Directive to Take Action)

8. That Policy D-295.328, “Promoting Physician Lifelong Learning,” be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: $1,000.

APPENDIX: RELEVANT AMA POLICY

D-295.328, "Promoting Physician Lifelong Learning"

1. Our AMA encourages medical schools and residency programs to explicitly include training in and an evaluation of the following basic skills:

(a) the acquisition and appropriate utilization of information in a time-effective manner in the context of the care of actual or simulated patients;
(b) the identification of information that is evidence-based, including such things as data quality, appropriate data analysis, and analysis of bias of any kind;
(c) the ability to assess one's own learning needs and to create an appropriate learning plan;
(d) the principles and processes of assessment of practice performance;
(e) the ability to engage in reflective practice.

2. Our AMA will work to ensure that faculty members are prepared to teach and to demonstrate the skills of lifelong learning.

3. Our AMA encourages accrediting bodies for undergraduate and graduate medical education to evaluate the performance of educational programs in preparing learners in the skills of lifelong learning.

4. Our AMA will monitor the utilization and evolution of the new methods of continuing physician professional development, such as performance improvement and internet point-of-care learning, and work to ensure that the methods are used in ways that are educationally valid and verifiable.

5. Our AMA will continue to study how to make participation in continuing education more efficient and less costly for physicians.

D-295.313, "Telemedicine in Medical Education"

1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations.

2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals.

3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training.

D-295.330, "Update on the Uses of Simulation in Medical Education"

Our AMA will:

1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;

2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;

3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;

4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;

5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

H-315.969, "Medical Student Access to Electronic Health Records"

Our AMA:
(1) recognizes the educational benefits of medical student access to electronic health record (EHR) systems as part of their clinical training;

(2) encourages medical schools, teaching hospitals, and physicians practices used for clinical education to utilize clinical information systems that permit students to both read and enter information into the EHR, as an important part of the patient care team contributing clinically relevant information;

(3) encourages research on and the dissemination of available information about ways to overcome barriers and facilitate appropriate medical student access to EHRs and advocate to the Electronic Health Record Vendors Association that all Electronic Health Record vendors incorporate appropriate medical student access to EHRs;

(4) supports medical student acquisition of hands-on experience in documenting patient encounters and entering clinical orders into patients' electronic health records (EHRs), with appropriate supervision, as was the case with paper charting;

(5) (A) will research the key elements recommended for an educational Electronic Health Record (EHR) platform; and (B) based on the research--including the outcomes from the Accelerating Change in Medical Education initiatives to integrate EHR-based instruction and assessment into undergraduate medical education--determine the characteristics of an ideal software system that should be incorporated for use in clinical settings at medical schools and teaching hospitals that offer EHR educational programs;

(6) encourage efforts to incorporate EHR training into undergraduate medical education, including the technical and ethical aspects of their use, under the appropriate level of supervision;

(7) will work with the Liaison Committee for Medical Education(LCME), AOA Commission on Osteopathic College Accreditation (COCA) and the Accreditation Council for Graduate Medical

Education (ACGME) to encourage the nation's medical schools and residency and fellowship training programs to teach students and trainees effective methods of utilizing electronic devices in the exam room and at the bedside to enhance rather than impede the physician-patient relationship and improve patient care; and

(8) encourages medical schools and residency programs to: (a) design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training; (b) provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice; and (c) provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions.

H-480.940, "Augmented Intelligence in Health Care"

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.

3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

4. Encourage 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.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

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REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-19)
Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)
(Reference Committee C)

EXECUTIVE SUMMARY

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks that the American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide. Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," asks that the AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and behavioral health issues in physicians and medical students. This report considers appropriate deliverables to fulfill these directives and to further establish the AMA's leadership role in this area.

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than in the general population. The AMA has studied the mental and physical toll that medical education exacts on medical students as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. AMA policy addresses the long-standing and deeply ingrained stigma against physicians, residents, and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications. Organizations such as the National Academy of Medicine, Federation of State Medical Boards, and Accreditation Council for Graduate Medical Education (ACGME) have begun to recognize the scope of this critical issue and are moving to address the problem. The AMA has also taken steps to decrease physician and medical trainee stress and improve professional satisfaction through resources such as the AMA's STEPS Forward™ practice improvement strategies and the Ed Hub™.

In addition to providing education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using data from the validated Mini-Z assessment tool enables the AMA to work with the organizations to identify solutions, which helps improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

The AMA is planning to partner with a leading academic medical institution to conduct a pilot study using data to be obtained from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. This research, planned for broad dissemination through publication in a peer-reviewed journal, will help the AMA identify opportunities to better help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost to suicide each year. This analysis could also include comparison to the general U.S. population, comparison to rates of physician burnout, longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

It will also be important for the AMA to monitor progress that has been made by the Association of American Medical Colleges and the ACGME to collect data on medical student, resident, and fellow suicides to identify patterns that could predict such events.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-19

Subject: Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

AMA Policy D-345.984 (1), "Study of Medical Student, Resident, and Physician Suicide," asks:

> That our American Medical Association (AMA) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates (HOD) with recommendations for action.

Recognizing the importance and timeliness of this topic, the Council on Medical Education agreed that appropriate resources should be dedicated to identifying mechanisms for study, noting that meaningful and constructive review of this issue, and of the work done to date by other organizations, required additional time. Accordingly, this report was moved to the 2019 Annual Meeting.

This report also addresses Resolution 959-I-18, "Physician and Medical Student Mental Health and Suicide," introduced by the Indiana Delegation and referred by the AMA HOD; it asks:

> That our AMA create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with:
> 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction.
> 2) Vociferous, repeated, and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help.
> 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges.
> 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service.

BACKGROUND

Burnout in physicians, residents, and medical students has been widely reported in recent years in both the lay and scholarly press, and incidence of depression and suicide is greater in medical students, residents, and physicians than the general population.[1-7] A recent study conducted by the

AMA, Stanford University School of Medicine, and Mayo Clinic shows rates of physician burnout in 2017 declined to 44 percent from 54 percent in 2014.[8] While burnout may have declined to levels present in 2011, the proportion of physicians screening positive for depression has modestly increased to nearly 42 percent.[8] Medical school and residency are stressful periods of physician training, each with their own dynamic. Many medical students experience substantial distress, which contributes to a decline in mental health and well-being. The American Medical Student Association reports that medical students are three times more likely to commit suicide than the rest of the general population in their age range in other educational settings.[4] Residents and practicing physicians also experience depression and burnout, and because they often lack a regular source of care, face barriers to the prompt diagnosis and treatment of behavioral disorders.[9] Stress, depression, and burnout are risk factors for suicidal ideation and suicide deaths.[9]

Resources such as hotlines exist for individuals experiencing suicidal ideation and are available from a number of reputable local, state, and national sources. In a recent Medscape report, based on a survey of more than 15,000 physicians in 29 specialties, 14 percent of respondents indicated that they had felt suicidal, and one percent had attempted suicide.[10] More than half of physicians who had thoughts of suicide told someone (therapist, family member, friend/colleague), but only two percent who had thoughts of suicide used a suicide hotline.[10]

Institutions and physician associations have begun to recognize the scope of this critical issue and are moving to address the problem.[11-12] The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience is exploring recommendations in this regard, working with more than 150 health care organizations to raise visibility about clinician burnout and developing a commentary that calls on health systems to consider hiring chief wellness officers.[13]

QUANTIFYING THE RATES OF PHYSICIAN SUICIDE

As early as the late 19th century,[14-18] and throughout the 20th and 21st centuries, reports quantifying the rates of physician suicide have been presented in health care journals and industry publications, and more recently in mainstream media. Studies of physician suicide rates compared to the general U.S. population have resulted in conflicting conclusions—some indicating physicians are more prone to suicide, and others demonstrating no significant difference. Medical student and resident/fellow deaths have been studied in more recent years. Inclusion of a literature review in this report is important to demonstrate the various modes of study and sources of data over time, and the implications of study methods for future efforts to quantify physician, resident/fellow, and medical student suicide rates.

In the late 1800s and into the 20th century, the primary source of data on physician deaths used by researchers was the AMA's Deceased Physicians file, which provided information on hundreds of thousands of deceased physicians from the early 19th century to the mid-1960s.[19-21] The cause of death listed in the records was obtained by various means, including *JAMA* obituaries, which cited death certificates and autopsy reports.[22-23] For example, one study published in 1926 concluded from AMA's data that the suicide rate of white male physicians in the U.S. was 45.4 out of 100,000.[24] Another study, using AMA's records from 1967 to 1972, showed the rates of suicide in American female physicians was 40.7 per 100,000, higher than male physician suicides during the same time range.[25] A study of death certificates in California from 1959 to 1961 found that physicians and health care workers were twice as prone to commit suicide when compared to the general population.[20] A 1977 *JAMA* article claimed that physicians took their own lives at a rate equivalent to one medical school class each year, but cited no specific number or source for this information.[26]

In the later part of the 20th century, researchers began using the National Occupational Mortality Surveillance (NOMS) database to identify causes of death for physicians, which was deemed a more accurate and reliable source than the AMA information.[27-28] The data in NOMS is sourced from state vital records (death certificates) and lists the proportionate mortality ratio for the total population.[29] The Social Security Death Index, another source of mortality information used by researchers, records the deaths of anyone in the U.S. who was issued a social security number. The Centers for Disease Control and Prevention (CDC) has several databases featuring varying degrees and descriptions of mortality and manner of death information. The CDC in 2016 published a study of suicides in 17 states using cause of death information from the National Violent Death Reporting System. This limited study concluded that the suicide rate for health care practitioners was 17.4 per 100,000 population.[30] This study was later found to have included erroneous data, however, and the authors are reanalyzing the findings.

Most of these studies call out limitations in the availability, reliability, and consistency of the data used to identify causes of death and occupation. A test of accuracy of the *JAMA* obituaries was conducted on a small sample, and it was determined that only half of the causes of death listed were accurate when compared with records from the state's department of health computerized records.[19] *JAMA*'s editor, in a quoted communication, alluded to the incompleteness of the obituary data and acknowledged that this was in part because some suicides may be listed on a death certificate or autopsy report as something other than suicide, such as respiratory failure.[31] *JAMA* also would not include the cause of death if requested by the family of the deceased physician, further limiting the completeness of the records.[28] Even death certificates, the primary vital record used by secondary sources, are not 100 percent consistent, accurate, or complete. Studies have found errors in manner of death certification in approximately 33 percent to 41 percent of cases.[32-34] Other studies have demonstrated variance in how different medical examiners interpret facts surrounding a decedent's death and how they ultimately report manner of death.[35-36]

SOURCES FOR COLLECTING DATA TO STUDY SUICIDE STATISTICS IN THE UNITED STATES

The databases and reports shown in Table 1 were identified as sources for collecting data to study suicide statistics in the United States.

Table 1. Sources for Data on Suicide Statistics in the United States

Source	Type of Data
Centers for Disease Control and Prevention	Fatal Injury Reports Leading Cause of Death Reports Mortality Reports National Vital Statistics System National Violent Death Reporting System National Occupational Mortality Surveillance Wide-ranging Online Data for Epidemiologic Research National Death Index
American Medical Association	JAMA Obituaries Deceased Physicians Masterfile (1906-present) Directory of Deceased American Physicians Vols. 1 & 2 (1804-1929)
World Health Organization	Compiled from member state local databases

Department of Defense	Department of Defense Suicide Event Annual Reports
Department of Veterans Affairs	National Suicide Data Report
Bureau of Justice Statistics	Suicide and Homicide in State Prisons and Local Jails
Social Security Administration	Social Security Death Index
Other	State and Local Vital Records; Legacy Obit

Although generally reliable, some inconsistency also exists in the recording of a deceased person's primary occupation, somewhat limiting the ability of researchers to accurately determine rates of suicide among specific populations, such as physicians, residents, or medical students. Occupation has long been a captured data point on death certificates, but it has not always been codified, utilized, and monitored the way it is today.[37] More recently, occupation and industry information have become more reliable.[38] Occupation information can now be recorded in most electronic health records (EHRs), helping to capture accurate information on the death certificates, but it is not required, and evidence shows it may not be consistently used.[39-41]

Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics.[42] Experts have also observed that cultural attitudes toward suicide determine how suicide is defined and how "intention to die" is legally interpreted.[43] These effects, as well as differing procedures for obtaining evidence about the death, cause coroners to vary in their definitions and reporting processes. Some believe this variation makes official statistics valueless and too unreliable to compare the suicide rates of countries, districts, or of demographic and other groups; to discern trends; or to investigate the social relations of suicide. However, other researchers disagree and have concluded that, despite inconsistency, the statistics still have utility.[44]

RELEVANT WORK OF OTHER ORGANIZATIONS

Accreditation Council for Graduate Medical Education

In 2017 the Accreditation Council for Graduate Medical Education (ACGME) studied the number and causes of resident deaths by matching their deceased resident data with cause of death information obtained from the National Death Index (NDI), a comprehensive database managed by the CDC. From this research they identified suicide as the leading cause of death for male trainees, the second leading cause for female trainees, and the second leading cause of death overall.[45] The cause of death data sourced from the NDI produced a 94 percent match to records in the ACGME's database, suggesting that these data represent an accurate and reliable source that could be used for future study.

National Academy of Medicine

The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience recently launched the Clinician Well-Being Knowledge Hub. The Hub is intended to provide resources to help organizations learn more about clinician burnout and solutions.[13] The repository contains peer-reviewed research, toolkits, and other resources for health system administrators and clinicians.

American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention (AFSP) has developed an Interactive Screening Program (ISP), which is in place for use by institutions of higher education, including undergraduate and medical schools, and which has been customized for use by workforces in multiple industries.[46] This initiative identifies individuals who may be at risk for suicide by offering them the opportunity to participate in an anonymous online screening.

UC San Diego Health Education Assessment and Referral Program

The UC San Diego Health Education Assessment and Referral (HEAR) Program, in collaboration with the AFSP, also provides a program of ongoing education and outreach, which encourages medical students, residents, and faculty, as well as pharmacists, nurses, and other clinical staff, to engage in an online, anonymous, interactive screening program.[47] The AFSP program model has been adopted by many schools of medicine and is used by clinicians of all disciplines.

Other Organizations

The AMA, American Osteopathic Association, and state and specialty medical associations are also positioned to help alleviate physician stress and burnout. CME Report 1-I-16, "Access to Confidential Health Services for Medical Students and Physicians,"[48] provides an overview of potential solutions by several key stakeholders including accrediting agencies, medical schools, residency/fellowship programs, employers, hospitals, and professional associations, including the AMA.

RELEVANT WORK OF THE AMA

The AMA has studied the mental and physical toll that medical education exacts on medical students and resident/fellow physicians as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the skills required to practice medicine. Specific AMA policy mandates and recommendations related to this topic are shown in the Appendix. AMA policy also addresses the long-standing and deeply ingrained stigma against physicians and students who seek care for either physical or behavioral health issues, partly due to concerns of career and licensure implications.

Work of Professional Satisfaction and Practice Sustainability (PS2) and STEPS Forward™

The AMA is already taking steps to decrease physician and medical student/trainee stress and improve professional satisfaction through resources such as the STEPS Forward™ practice improvement module, "Preventing Physician Distress and Suicide," which offers targeted education for practicing physicians seeking information about how to help their physician colleagues who may need support. The AMA is also developing an education module that will help physicians, residents, and medical students learn about the risks of physician suicide, identify characteristics to look for in patients who may be at risk of harming themselves, and recognize the warning signs of potential suicide risk in colleagues. The module, to be offered with continuing medical education credit on the AMA's Ed Hub™, will also provide tools and resources to guide learners in supporting at-risk patients and colleagues.

In addition to education resources for physicians, the AMA works with organizations to help them understand the incidence of burnout in their workplaces. Using the validated Mini-Z assessment tool, organizations are assigned a burnout score, along with targeted data on culture and workplace

efficiency factors that can lead to stress and burnout for physicians. These data enable the AMA to work with the organizations to identify solutions, helping improve environmental, organizational, or cultural factors that, if not addressed, could lead to heightened stress or suicide risk for some.

Accelerating Change in Medical Education

Schools in the AMA's Accelerating Change in Medical Education Consortium formed a student wellness interest group to share ideas across schools about best practices to ensure wellness and counter burnout. The results of a wellness survey conducted among medical school consortium members showed that 81 percent of respondents employ an individual tasked with focusing on student wellness to at least some extent; these roles range from program coordinators to graduate assistants to deans who also serve as wellness directors. Most schools had dedicated wellness committees, with budgets up to $7,000 annually.

DISCUSSION

Overall, the available literature suggests that obtaining both accurate manner of death and specific occupation information is the most reliable means of quantifying rates of suicide among physicians. However, most researchers still face challenges with this approach. Primary barriers include:

- Cost and limitations of obtaining and using the data from reliable sources;
- Irregular/restricted access to mortality information, including date, cause, and manner of death;
- Inconsistency in medical examiner interpretation of cause/manner of death;
- Lack of standard physician and medical examiner/coroner training on completion of the death certificate;
- Possible underutilization of standard code-sets to report manner of death;
- Social or cultural stigma associated with reporting a death as a suicide;
- Underutilization of "occupation" field in electronic heath records; and
- Inaccurate or inconsistent assignment of occupation upon death.

Physician-focused Programs and Resources

Resolution 959-I-18 asks the AMA to create a committee tasked with establishing a 24-hour mental health hotline for physicians and medical students to access when in need. Establishing and maintaining a mental health hotline is resource intensive, requiring investments in staffing, infrastructure, management, training, costs of licensing, and accreditation to operate. Operating the Crisis Call Center, a backup center for the National Suicide Prevention Lifeline, costs approximately $1.1 million per year.[49] A smaller, Louisiana based non-profit operation, which also fields calls directed from the national lifeline, operates on $350,000 per year.[49] Most of the funding for local services comes from county and city sources, as well as in-kind and private donations. Accredited programs may receive a small stipend from the Substance Abuse and Mental Health Services Association. Due to limited available funds, many programs rely on volunteers more than paid staff.[50-51] In addition to substantial costs, establishing a new, physician-focused mental health line may introduce potential liabilities for the AMA. Considering the extensive resources involved, the potential for liability, and demonstrated low rates of usage,[10] it is not recommended that the AMA pursue an independent mental health hotline at this time. However, the AMA has evaluated Employee Assistance Program (EAP) service providers to explore the option of piloting a service to AMA members as a membership benefit. Some EAP services provide participants with 24/7 telephone or video access to qualified and trained counselors, wellness services, and critical

incident support. This evaluation is in its early stages, and a decision to pursue various options will be considered.

Removing the Stigma Associated With Behavioral Health Treatment

Resolution 959-I-18 also asks the AMA to create a committee to work with state medical licensing boards and hospitals to help remove any stigma of behavioral health and to alleviate physician and medical student fears about the consequences of behavioral health treatment on their medical license and hospital privileges. In addition to multiple policies expressing the AMA's commitment to resolving this issue, CME Report 6-A-18, "Mental Health Disclosures on Physician Licensing Applications," adopted at the 2018 Annual HOD Meeting, addressed concerns that have been raised about the presence and phrasing of questions on licensing applications related to current or past impairment. These questions may be discouraging physicians from seeking appropriate treatment because of fear of stigmatization, public disclosure, and the effect on one's job due to licensing or credentialing concerns.[52] Many medical and osteopathic licensing boards recognize that the manner in which they evaluate the fitness of potential licensees has the potential to create a barrier that prevents licensees from seeking help. Some state boards, such as the Oregon and Washington State Medical Boards, have taken steps to address these barriers. In addition, the Federation of State Medical Boards has established a Workgroup on Physician Wellness and Burnout. The workgroup is addressing symptoms that arise from the practice of medicine for which physicians may be reluctant to seek treatment due to concern about the presence and phrasing of questions on licensing applications about behavioral health, substance abuse, and leave from practice. The workgroup is also seeking to draw an important distinction between physician "illness" and "impairment" as well as determine whether it is necessary for the medical boards to include probing questions about a physician applicant's behavioral health on licensing applications in the interests of patient safety.

Current and Planned AMA Efforts

<u>Updating the AMA Physician Masterfile for Research</u>

The AMA's Deceased Physician database, which includes records of deceased physicians dating back to 1804, includes 242,541 physicians (as of January 2019). Currently only 107 records have a manner of death listed. This information is not made available on a consistent basis by the sources the Masterfile team relies on for mortality information. To capture the manner of death information needed to pursue relevant research, the Masterfile needs to be supplemented with third-party information that is made available at the individual level. To advance research in quantifying rates of physician suicide, as well as to identify patterns, risk factors, and methods by which to prevent suicides, the AMA is exploring options to enhance its Physician Masterfile data by collecting and maintaining manner of death information for physicians listed as deceased.

The AMA is partnering with a leading academic medical institution to conduct a pilot study using data from the National Death Index (NDI) to identify manner of death for a subset of the AMA Masterfile population. The goals of this initial research are to study and quantify incidence of suicide among physicians, residents, and medical students, and to evaluate the quality and reliability of the NDI data to determine if they represent a viable and cost-effective source for further, long-term study. Results from this research are anticipated by the end of 2019. In addition to staffing, establishment of processes, and ongoing data security requirements, there are financial costs for the procurement of these data from the NDI. Obtaining the data for the planned 2019 study will cost between $65,000 and $80,000. Obtaining NDI data for all individuals whose date of death occurred from 1979 through 2017 (the years for which NDI data is available) would require

approximately $600,000. Based on the average number of records updated as deceased in the Masterfile each year, requesting future NDI data every year for long-term study would cost approximately $30,000 per year.

This research, planned for broad dissemination through publication in a peer-reviewed journal, will assist the AMA in identifying opportunities to better help physicians, residents, and medical students reduce factors that contribute to suicidal ideation and ultimately could help reduce the number of lives lost each year. This analysis could also include comparison to the general US population, comparison to rates of physician burnout, and longitudinal evaluation for various cohorts, as well other variables allowed by the data. The manner of death data could also enable additional study into physician mortality trends, such as patterns of other disease states or geographic variations.

Other data sources were explored during the preparation of this report, including the National Occupational Mortality Surveillance, Social Security Administration Death Index, National Violent Death Reporting System, National Association for Public Health Statistics and Information Systems, and the CDC Wide-ranging OnLine Data for Epidemiologic Research. While these sources are valuable for observing aggregate data, none allows access to the individual-level information needed to match records in the Masterfile or conduct research rigorous enough to accurately quantify the incidence of suicide among physicians.

Ongoing Data Collection

Collecting manner of death information on an ongoing basis will be important should the AMA choose to continue long-term study of physician suicide. In addition to the NDI data previously outlined, the AMA is continuously exploring sources and potential new mechanisms through which the Masterfile team can obtain the manner of death information for ongoing updates.

At its 2018 Interim Meeting, the AMA adopted policy that urges the Liaison Council on Medical Education (LCME) and the ACGME to collect data on medical student and resident/fellow suicides to enable these organizations and the AMA to better identify patterns that could predict, and ultimately prevent, further suicides. In response, the LCME voted at its February 2019 meeting not to participate in the data-gathering requested through the AMA policy, in that the LCME felt that such data gathering and analysis was beyond its purview. A current LCME standard requires medical schools to include programs that promote student well-being. The AMA will continue to monitor progress made by the AAMC and ACGME on this and related objectives.

Creating a Physician and Medical Student Suicide Prevention Committee

Resolution 959-I-18 asks the AMA to create a committee with the goal of addressing suicides and behavioral health in physicians and medical students. As noted above, the AMA has already carried out extensive and sustained work in developing policy, communications, and resources to decrease physician and medical trainee stress, improve professional satisfaction, and decrease the stigma associated with mental illness that physicians may face when applying for licensure and hospital privileges. As also noted above, the AMA has explored the establishment of a 24-hour mental health hotline for physicians and medical students and is currently exploring EAP service providers that provide 24/7 access to counselors, wellness services, and critical incident support. For these reasons, the formation of a new committee would duplicate existing AMA efforts, and the Council on Medical Education believes that such a body is not necessary at this time.

SUMMARY AND RECOMMENDATIONS

The routine occurrence of burnout, depression, and suicide in physicians, residents/fellows, and medical students warrants continued study. Several recommendations have been offered to collect data on the actual incidence of physician and physician-in-training suicide. The Council on Medical Education therefore recommends the following recommendations be adopted in lieu of Resolution 959-I-18 and the remainder of this report be filed.

1. That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies. (Directive to Take Action)

2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events. (Directive to Take Action)

3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral health services. (Directive to Take Action)

4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students. (Directive to Take Action)

5. That Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME. (Rescind HOD Policy)

Fiscal Note: $81,500.

APPENDIX: RELEVANT AMA POLICIES

9.3.1, "Physician Health & Wellness"

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

(Issued: 2016)

D-345.984, "Study of Medical Student, Resident, and Physician Suicide "

Our AMA will: (1) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action; and (2) request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

(Res. 019, A-18 Appended: Res. 951, I-18)

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

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to: A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means; B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees; C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient

safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
    A. be available to all medical students on an opt-out basis;
    B. ensure anonymity, confidentiality, and protection from administrative action;
    C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
    D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

(CME Rep. 01, I-16 Appended: Res. 301, A-17 Appended: Res. 303, A-17 Modified: CME Rep. 01, A-18 Appended: Res. 312, A-18)

H-295.927, "Medical Student Health and Well-Being"

The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities.

(BOT Rep. 1, I-934 Modified with Title Change: CSA Rep. 4, A-03 Reaffirmed: CME Rep. 2, A-13)

H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.
(Sub. Res. 84, I-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed and appended: CME Rep. 4, I-98 Reaffirmed: CME Rep. 2, A-08 Modified: CME Rep. 01, A-18)

H-310.907, "AMA Duty Hours Policy"

Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
(CME Rep. 5, A-14 Modified: CME Rep. 06, I-18)

D-310.968, "Physician and Medical Student Burnout"

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

(CME Rep. 8, A-07 Modified: Res. 919, I-11)

H-405.957, "Programs on Managing Physician Stress and Burnout"

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.

2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

(Res. 15, A-15 Appended: Res. 608, A-16)

H-405.961, "Physician Health Programs"

Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
(CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)

D-405.990, "Educating Physicians About Physician Health Programs"

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.
(Res. 402, A-09 Modified: CSAPH Rep. 2, A-11 Reaffirmed in lieu of Res. 412, A-12 Appended: BOT action in response to referred for decision Res. 403, A-12)

H-345.973, "Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians"

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.
(Res. 915, I-15 Revised: CME Rep. 01, I-16)

H-275.970, Licensure Confidentiality

1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger.

2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."
CME Rep. B, A-88 Reaffirmed: BOT Rep. 1, I-93 CME Rep. 10 - I-94 Reaffirmed: CME Rep. 2, A-04 Reaffirmed: CME Rep. 2, A-14 Appended: CME Rep. 06, A-18

D-295.319, Discriminatory Questions on Applications for Medical Licensure
Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate diagnosis and treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health.
(Res. 925, I-09)

D-275.974, Depression and Physician Licensure
Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.
(Res. 319, A-05 Reaffirmed: BOT action in response to referred for decision Res. 403, A-12)

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JOINT REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION AND COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-19)
Protecting Medical Trainees from Hazardous Exposure (Resolution 301-A-18)
(Reference Committee C)

EXECUTIVE SUMMARY

Resolution 301-A-18, "Protecting Medical Trainees from Hazardous Exposure," introduced by the Illinois Delegation, asked that our American Medical Association (AMA): 1) call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials; 2) encourage the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education to create standards that allow students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs; 3) support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to methyl methacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs; and 4) support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers.

Due to the complexity of the issues surrounding this topic, the resolution was referred.

This report:

- Provides legal definitions of hazardous chemicals, health hazards and physical hazards, and describes occupational exposure limits;
- Summarizes expected hazardous agent exposure in health care;
- Describes accreditation standards for medical school and residency/fellowship training regarding exposure to hazardous agents; and
- Discusses the need for learners' confidence in hazardous agent protection as well as greater clarity on hazardous agent avoidance.

The report recommends revising AMA Policy H-295.939, "OSHA Regulations for Students," to include residents and fellows. In addition, the report recommends new policy that: 1) encourages the Accreditation Council for Graduate Medical Education to require education on and demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties; 2) recommends medical schools include in their policies on hazardous exposure options for students to reduce exposure that will not negatively affect their ability to progress in their education; and 3) encourages medical schools and institutions with medical learners to vigilantly update educational material and protective measures on hazardous agent exposure, and make this information readily accessible.

JOINT REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CME/CSAPH Joint Report 1-A-19

Subject:	Protecting Medical Trainees from Hazardous Exposure (Resolution 301-A-18)
Presented by:	Carol Berkowitz, MD, Chair, Council on Medical Education Robyn F. Chatman, MD, MPH, Chair, Council on Science and Public Health
Referred to:	Reference Committee C (Nicole Riddle, MD, Chair)

Resolution 301-A-18, "Protecting Medical Trainees from Hazardous Exposure," introduced by the Illinois Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks the AMA to:

1) call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials;

2) encourage the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education to create standards that allow students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs;

3) support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to methyl methacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs; and

4) support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers.

Testimony during the meeting before Reference Committee C and the HOD on this complex issue reflected strong support for the importance of protecting students/trainees and colleagues from exposure to hazardous materials. In addition, it was noted that taking measures of self-protection should not negatively impact one's standing in a training program or workplace. Other testimony encouraged a more expansive proposed policy, to include all physicians and surgeons, and to incorporate hazardous materials more generally. That said, determining which substances would be allowed, and the acceptable level of risk for those substances, pointed out the complexity of the issue, and the need for referral.

This report: 1) provides legal definitions of hazardous chemicals, health hazards and physical hazards, and describes occupational exposure limits; 2) summarizes expected hazardous agent exposure in health care; 3) summarizes health system processes addressing hazardous materials and exposure; 4) describes accreditation standards for medical school and residency/fellowship training regarding exposure to hazardous agents; and 5) concludes with a discussion that emphasizes the need for learners' confidence in hazardous agent protection as well as greater clarity on hazardous agent avoidance.

BACKGROUND

The Occupational Safety and Health (OSH) Act of 1970 was enacted "to assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health; and for other purposes."[1]

With the OSH Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) as part of the United States Department of Labor and established the National Institute for Occupational Safety and Health (NIOSH), a part of the Centers for Disease Control and Prevention (CDC). OSHA assures safe and healthful working conditions by setting and enforcing standards and by providing training, outreach, education and assistance. NIOSH researches and publishes worker safety recommendations which contain the latest U.S. Public Health Service guidelines.

Definition of Hazardous Chemicals

OSHA's Hazard Communication Standard (HAZCOM), 29 CFR 1910.1200, was adopted in 1983, expanded in scope in 1987, and aligned with the United Nations' Globally Harmonized System of Classification and Labeling of Chemicals (GHS) in 2012.[2] The purpose of HAZCOM is to ensure that the hazards of all chemicals produced or imported are classified, and that information concerning the classified hazards is transmitted to employers and employees. The transmittal of information is to be accomplished by means of comprehensive hazard communication programs, which are to include container labeling and other forms of warning, safety data sheets, and employee training.

HAZCOM defines a "hazardous chemical" as "any chemical which is classified as a physical hazard or a health hazard, a simple asphyxiant, combustible dust, pyrophoric gas, or hazard not otherwise classified.[2] "A "health hazard" is defined as "a chemical which is classified as posing one of the following hazardous effects: acute toxicity (any route of exposure); skin corrosion or irritation; serious eye damage or eye irritation; respiratory or skin sensitization; germ cell mutagenicity; carcinogenicity; reproductive toxicity; specific target organ toxicity (single or repeated exposure); or aspiration hazard." A "physical hazard" is defined as "a chemical that is classified as posing one of the following hazardous effects: explosive; flammable (gases, aerosols, liquids, or solids); oxidizer (liquid, solid or gas); self-reactive; pyrophoric (liquid or solid); self-heating; organic peroxide; corrosive to metal; gas under pressure; or in contact with water emits flammable gas." HAZCOM addresses both physical hazards (e.g., flammability or reactivity) and health hazards (e.g., carcinogenicity or sensitization). For ease of language this report will use the term "hazardous agents" to refer all hazards covered by HAZCOM.

HAZCOM stipulates that employers shall provide employees with effective information and training on hazardous agents in their work area at the time of their initial assignment and whenever a new chemical hazard the employees have not previously been trained about is introduced into

their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and safety data sheets.

Exposure Limits

An occupational exposure limit (OEL) is an upper limit on the acceptable concentration of a hazard in a workplace for a material or class of materials. Several different OELs exist in the United States and include:

- Permissible exposure limit (PEL), set by OSHA;
- PELs set by the California Division of Occupational Safety and Health (Cal/OSHA);
- Recommended exposure limit (REL), set by NIOSH; and
- Threshold Limit Value (TLV) and Biological Exposure Indices (BEIs), set by the American Conference of Governmental Industrial Hygienists (ACGIH).

The OSHA PEL is the legally enforceable limit in the United States for exposure of an employee to a chemical substance or physical agent, such as high-level noise.[3] Cal/OSHA has established an extensive list of PELs that are enforced in workplaces under its jurisdiction, no less protective than the OSH Act, and not enforceable in establishments outside of Cal/OSHA's jurisdiction. However, of all states that have OSHA-approved State Plans, California has the most extensive list of OELs, which can provide information on acceptable levels of chemicals in the workplace for other states and organizations.

The NIOSH REL is a non-mandatory, recommended occupational chemical exposure limit.[4] NIOSH RELs are authoritative federal agency recommendations established according to the legislative mandate for NIOSH to recommend standards to OSHA. RELs are intended to limit exposure to hazardous agents in workplaces. In developing RELs and other recommendations to protect worker health, NIOSH evaluates all available medical, biological, engineering, chemical, and trade information relevant to the hazard.

ACGIH is a 501(c)(3) charitable scientific organization that advances occupational and environmental health. TLVs are airborne concentrations of chemical substances and represent conditions under which it is believed that nearly all workers may be repeatedly exposed without adverse effects. BEIs are guidance values for assessing biological monitoring of concentrations of chemicals in biological matrices. ACGIH TLVs and BEIs are health-based values and are not intended to be used as legal standards without an analysis of other factors necessary to make appropriate risk management decisions. The ACGIH TLVs are widely recognized as authoritative and are required to be included on safety data sheets by HAZCOM.

OSHA recognizes that many of its PELs are outdated and reflect inadequate measures of worker safety. Both OSHA and NIOSH recommend that employers take actions to keep worker exposures below the NIOSH REL. NIOSH provides a Pocket Guide to Chemical Hazards (NPG) that gives general industrial hygiene information for hundreds of chemicals/classes and presents key data for chemicals or substance groupings that are found in workplaces.[4] The OSHA PEL Tables include a side-by-side comparison of OSHA PELs, Cal/OSHA PELs, NIOSH RELs and ACGIH TLVs.[3] Additionally, OSHA provides general information regarding training requirements for employers and offers resources for use such as publications and videos.[5]

Health Care-specific Information

The OSHA PEL Tables contain many chemicals prevalent in health care settings including, but not limited to, methyl methacrylate, ethylene oxide, and formaldehyde/formalin.[3] Recognizing that many hazardous chemicals and medications are present in health care settings and may pose an exposure risk for health care workers, patients, and others, NIOSH has developed a list of antineoplastic and other hazardous drugs specific to health care.[6] OSHA provides access to a "Hospital eTool" that focuses on some hazards and controls found in the health care setting and describes standard requirements and recommended safe work practices for employee safety and health.[7] NIOSH also provides resources regarding reproductive health and the workplace for men and women and outlines the risks from some specific, and health care setting-related, chemicals.[8]

Medical specialty societies have provided additional information and resources regarding safety in the health care setting. The American College of Radiology, with the American Association of Physicists in Medicine, publishes a manual detailing radiation safety officer resources. This guide provides models and educational materials for medical imaging facilities, including personnel monitoring, that cover pregnancy and breastmilk concerns.[9] The American Academy of Orthopaedic Surgeons (AAOS) published a document outlining risks and precautions for pregnant orthopaedic surgeons in the workplace. The document provides information on a variety of risks encountered in an operating room including anesthetic gases, radiation, and methyl methacrylate.[10]

The evidence base used by experts to evaluate hazardous agents is updated when new research emerges and new methods of risk avoidance or mitigation are developed. For example, the AAOS and others agree that although methyl methacrylate has historically been thought to be teratogenic, current research and evidence show that fumes have no effect on pregnant rodents and were not transmitted to the serum or breastmilk of breastfeeding surgeons.[11,12] Authors note that the greatest risk of exposure is during the mixing process; this risk can be reduced by using vacuum-mixing and extraction hoods.

HEALTH SYSTEM PROCESSES ADDRESSING HAZARDOUS MATERIALS AND EXPOSURE

Hospitals are required by The Joint Commission to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results; most do this by establishing safety committees. Safety committee response plans should include policies and procedures that address exposures and require all-employee education about material safety. Employed physicians are required to complete such education (usually computer-based learning modules). Safety committees address the full range of hazardous materials, including cleaning materials, laboratory reagents, medical gases, contrast materials, and nuclear medicine products. Members of the medical staff who are not employees, and trainees who rotate through an institution for educational purposes, may not be required to complete such educational modules and may not know about Material Safety Data Sets (MSDSs) that the hospital has catalogued and how to respond to hazardous exposures.

STANDARDS REGARDING HAZARDOUS EXPOSURE IN EDUCATIONAL SETTINGS

Although the discussion concerning hazardous exposure during the 2018 Annual Meeting suggested broadening hazardous agent exposure recommendations to include physicians in practice, those physicians are protected against hazardous agent exposure by OSHA workplace safety regulations, as outlined above, even if they are not specifically trained about the regulations or safety procedures. Less certain are the protections afforded learners in health care settings;

therefore, this report will concentrate on education about hazardous agent exposure and standards and regulations regarding prevention of exposure (including voluntary avoidance) for medical students, residents, and fellows. Our AMA recognizes that this issue also extends to non-physician health professions students and trainees.

Medical School Accreditation Standards Regarding Hazardous Exposure

The Liaison Committee on Medical Education (LCME) accredits allopathic medical education programs leading to the MD degree in the United States. Requirements regarding medical student exposure to hazards are addressed in Standard 12: Medical Student Health Services, Personal Counseling, and Financial Aid Services, which includes 12.8:[13]

> A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards, including the following:
> - The education of medical students about methods of prevention
> - The procedures for care and treatment after exposure, including a definition of financial responsibility
> - The effects of infectious and environmental disease or disability on medical student learning activities
>
> All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk.

In assessing compliance with Standard 12.8, the LCME survey team during the site visit (typically occurring every 8 years) will ask the school to provide the following information:[14]

1. Does the medical school have policies related to infectious and environmental hazards? Do the policies explicitly address the education of students about preventing exposure; the procedures for treatment after exposure, including financial responsibility for treatment and follow-up; and the implications of infectious and/or environmental disease or disability on medical student participation in educational activities?

2. Describe how and when in the curriculum medical students are instructed about preventing exposure to infectious diseases and about protocols for treatment and follow-up in the case of an occupational exposure.

3. Describe how visiting medical students are informed about the procedures to be followed in the event of an occupational exposure.

4. Is there evidence that students are familiar with the policies and procedures to follow in the event of an environmental exposure?

The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA) accredits osteopathic medical education programs leading to the DO degree in the U.S. Element 5.3 addresses health and safety issues in colleges of osteopathic medicine (COM):[15]

> Element 5.3: Safety, Health, and Wellness: A COM must publish and follow policies and procedures that effectively mitigate faculty, staff, and student exposure to infectious and environmental hazards, provide education on prevention of such exposures, and address procedures for care and treatment after such exposures. A COM must also publish and follow policies related to student, faculty, and staff mental health and wellness and fatigue mitigation.

During the continuing accreditation process COCA requires evidence that its elements of accreditation are met. Evidentiary Submission 5.3 requires the COM to:

1. Provide the policies and procedures addressing safety and health issues.
2. Provide a link to where the documents are published.
3. Demonstrate how this information is provided to students.

Policies regarding hazardous exposure and education and training regarding prevention and avoidance are often available on medical school, health science center, or university websites. Examples are included in the Appendix.

Residency/Fellowship Program Accreditation Standards Regarding Hazardous Exposure

The Accreditation Council for Graduate Medical Education (ACGME) accredits residency and fellowship programs and sets requirements for training programs as well as the institutions in which training occurs.

A review of ACGME institutional requirements[16] reveals general recommendations regarding safety of trainees as well as patients. As part of the learning and working environment, the sponsoring institution must ensure trainees have "access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal" (III.B.1.a) and provide a healthy, safe and educational environment that provides for "safety and security measures for residents/fellows appropriate to the participating site" (III.B.7.d.(2))

The ACGME's Common Program Requirements (CPRs) include more specificity. The CPRs currently in effect include responsibilities of the program and its sponsoring institution to address resident well-being in several ways, including evaluating workplace safety data and addressing the safety of residents and faculty members (VI.C.1.c).[17] Program requirements that go into effect in July 2019 provide more detail. The program, with its sponsoring institution, must ensure healthy and safe learning and working environments that, among other things, provide "security and safety measures appropriate to the participating site." (I.D.2.d).[18] Concerning well-being, the revised CPRs provide background for VI.C.1.c:

> This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.[18]

A review of specific program requirements for specialties that may have increased exposure to hazardous agents revealed minimal discussion of hazardous agent exposures. Program requirements for radiology, vascular surgery, neurosurgery, orthopaedic surgery, cardiology, and endovascular surgical neuroradiology were reviewed.

Program requirements for neurosurgery, vascular surgery, cardiology, and orthopaedic surgery did not include any mention of exposure to hazardous agents. Requirements for endovascular surgical neuroradiology[19] stated that fellow eligibility for entry to the program include "a course in basic radiographic skills, including radiation physics, radiation biology, and radiation protection; and the pharmacology of radiographic contrast materials acceptable to the program director where the neuroradiology training will occur." (III.A.6.b.(1)). Not noted are the adverse effects of radiation exposure as a component of the medical knowledge that fellows are required to know.

Program requirements for radiology were the most extensive regarding hazardous agent exposure.[20] Didactic curriculum is to include a minimum of 80 hours of classroom and laboratory training in basic radionuclide handling techniques applicable to the medical use of unsealed byproduct material for imaging and localization studies (10 CFR 35.290)[21] and oral administration of sodium iodide I-131 for procedures requiring a written directive (10 CFR 35.392, 10 CFR 35.394). [IV.A.3.e.(5)]. These specific requirements are not those of ACGME or any health care accreditation agency but of the federal Nuclear Regulatory Commission; they appear in the Code of Federal Regulations.

Furthermore, residents in radiology programs must demonstrate competence in the ongoing awareness of radiation exposure, protection, and safety, and the application of these principles in practice [IV.A.5.a).(2).(e)]. And, finally, residents must have a minimum of 700 hours of training and work experience under the supervision of an authorized user (AU) in basic radionuclide handling techniques and radiation safety applicable to the medical use of unsealed byproduct material for imaging and localization studies (10 CFR 35.290) and oral administration of sodium iodide I-131 for procedures requiring a written directive (10 CFR 35.392, 10 CFR 35.394) [IV.A.6.f)]. Operational and quality control procedures should include ensuring radiation protection in practice, to include dosimeters, exposure limits, and signage [IV.A.6.f).(1)].[21]

Reducing Hazardous Exposure in Educational Settings

Medical school accreditation standards do not specifically address avoiding exposure to hazards that may be endemic to the educational environment. For example, what could a student expect if the student refuses a particular component of a rotation that puts him or her in proximity with a hazardous agent, in terms of completing the rotation? One college of osteopathic medicine catalog proactively addressed this issue by asking students to decide if they are comfortable with required levels of exposure prior to matriculation:

> Working and studying in these special environments may require the student to make an informed decision concerning continued participation because failure to participate in required classes could result in dismissal. Examples may include but are not limited to: students who believe they are allergic or sensitive to certain chemicals, students who are pregnant and are concerned about potential hazards to a developing fetus, or students who believe they are immuno-compromised or have increased susceptibility to disease. The student must decide upon their ability to participate prior to beginning school.[22]

Medical school deans of student affairs should be prepared to handle such requests and provide guidance to a student concerned about avoiding hazardous agent exposure. The type of counsel and outcomes will vary by the situation.

ACGME institutional and program requirements more generally address resident/fellow absences because of personal health or family circumstances, rather than an absence resulting from concerns about hazardous agent exposure. The CPRs note:

> VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.[18]

In addition, programs are to counsel residents that they may have to extend their length of training depending on the length of absence and specialty board eligibility requirements, and that teammates should assist colleagues in need and equitably reintegrate them upon return. Program requirements do not address the issue of avoidance of exposure to hazardous agents, and, as in medical schools, the subject is likely to be managed on a case-by-case basis.

COMMUNICATION ON HAZARDOUS CHEMICAL AGENT EXPOSURE FOR TRAINEES

A significant number of informational resources and standards are available—including OSHA requirements, OSHA's Hazard Communication Standard, NIOSH recommendations, and 22 state-level OHSA plans (which may be more stringent than federal requirements)—to outline the requirements for a safe environment for institutions with students and with residents and fellows (as employees). Furthermore, educational accreditation requirements mandate policies for both maintaining a safe learning environment and for educating trainees on workplace safety. In addition, specialty societies produce material on current safety measures for exposure to materials relevant to the specialty. Assuring that all information and material is kept current, and new information on hazardous agents is added when available, is essential to allow medical trainees the confidence to learn and work safely in the health care environment.

RELEVANT AMA POLICY

Existing AMA policy related to hazardous exposure during training is limited. Policy H-295.939, "OSHA Regulations for Students," encourages all health care-related educational institutions to apply existing Occupational Safety and Health Administration Blood Borne Pathogen Standards equally to employees and students. Policy D-135.987, "Modern Chemicals Policies," calls on the United States government to implement a comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use and encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.

SUMMARY AND RECOMMENDATIONS

It is recognized that the risk of hazardous agent exposure exists in the health care setting and that additional considerations, including reproductive health, may represent another level of risk. Exposure levels for hazardous agents for employees in a medical setting, including residents and fellows, are regulated by OSHA after all available medical, biological, engineering, chemical, and trade information relevant to the hazard are thoroughly researched and evaluated by NIOSH and others. Exposure levels for hazardous chemicals for medical students are dictated by the student's educational institution and often are the same as OSHA standards.

There are standard employee education processes on the topics of hazardous materials, how to locate MSDSs, minimizing risks of exposure, and proper responses to employee exposure. Such education is required of all employees of hospitals and health systems, including physicians. To make such educational modules available to students and trainees, and to require medical students, residents, and fellows to complete such educational modules (as do faculty, who are institutional employees), would not be a complex task. It would also seem feasible to require and monitor the completion of such education modules as a condition of program accreditation for a school of allopathic or osteopathic medicine or a residency or fellowship program.

Although the policies regarding hazardous agent exposure, education, and training vary depending on the medical school or residency program, accreditation standards require a healthy, safe and educational environment for medical students, residents, and fellows. It benefits educational and health care institutions to ensure that medical trainees are knowledgeable about hazards and confident that voluntary avoidance is possible, albeit with potential setbacks in educational and training progress. All learners should feel confident that the institutions in which they receive their education are attentive to the latest research and protective measures for their health and safety. The Council on Medical Education and the Council on Science and Public Health therefore recommend that the following recommendations be adopted in lieu of Resolution 301-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-295.939, "OSHA Regulations for Students," by addition and deletion, to read as follows:

   H-295.939, "~~OSHA Regulations for Students~~ Protecting Medical Trainees from Hazardous Exposure"
   Our AMA will ~~The AMA, working in conjunction with its Medical School Section, to~~ encourage~~s~~ all health care-related educational institutions to apply the ~~existing~~ Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen ~~S~~standard~~s~~ and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows~~students~~. (Modify Current HOD Policy)

2. That our AMA recommend that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site. (New HOD Policy)

3. That our AMA recommend a) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and b) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect her personal health status. (New HOD Policy)

4. That our AMA recommend that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff. (New HOD Policy)

5. That our AMA recommend that medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff. (New HOD Policy)

Fiscal Note: $500.

APPENDIX: EXAMPLES OF SCHOOL POLICY REGARDING HAZARDOUS EXPOSURE

Elson S Floyd College of Medicine, Washington State University

Policy Title: Medical Student Training on Universal Precautions and Biohazards

1.0 Policy Statement:
It is the Elson S. Floyd College of Medicine (ESFCOM) policy that all medical students, enrolled and visiting, learn precautions and infection control measures for pathogens and environmental hazards prior to patient contact and throughout matriculation.

4.0 Procedures
Ultimately, each student shares responsibility for his/her health and safety in the clinical/educational setting. Training begins with universal precautions prior to and during orientation and continues throughout foundational and clinical learning experiences.
Key policies and procedures, as well as locations of relevant information, will be provided during the student onboarding process.

Visiting medical students, prior to participation in ESFCOM sponsored clinical activities, will need to provide proof of appropriate universal precautions and post exposure care training. Verification of awareness of the ESFCOM online policies and protocols regarding Universal Precautions and Biohazards is required.

University of Texas Rio Grande Valley School of Medicine

The SOM will communicate with the university's Environmental Health, Safety, and Risk Management office (http://www.utrgv.edu/ehsrm) to promote a healthy and safe campus environment. This office oversees hazard communication, Occupational Safety and Health Administration compliance, indoor air quality, bloodborne pathogens, asbestos awareness, construction safety, accident investigation/reporting, ergonomics, and industrial hygiene.

The University of Colorado School of Medicine

Education and Training: Annually, all medical students are required to complete online modules entitled Hazardous Materials and Bloodborne Pathogens. The Hazardous Materials module includes: identification of workplace hazardous, use of personal protective equipment and response to a hazardous exposure. The Bloodborne Pathogens module provides instruction about: risks of bloodborne pathogens to health care workers, safeguards against bloodborne pathogen exposure, and how to manage exposures. Students must complete these modules annually. Students are not able to begin or continue clinical activities until satisfactory completion of the modules. Students have ongoing access to course material through online platform.

The University of California Irvine School of Medicine

Occupational Risk Training and Prevention

Participation in direct patient care activities can pose risks to health care professionals, particularly in terms of exposure to infectious diseases. The School of Medicine requires that all medical students participate in annual safety training that facilitates students' anticipation, recognition, and avoidance of potential occupational risks. The School of Medicine also provides practical training in safe practices so that students minimize risk in potentially hazardous situations, such as the

Anatomy lab and the operating room. A particular emphasis is placed on strict adherence to universal precautions. Finally, students are required to show proof of immunity to a series of vaccine-preventable diseases as outlined in the AAMC Standardized Immunization Form.

…Students receive training on occupational and environmental hazards as part of their orientation to the school. Students are required to complete an annual online safety training, which reinforces this information.

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[2] 29 CFR 1910.1200. https://www.ecfr.gov/cgi-bin/text-idx?rgn=div8&node=29:6.1.1.1.1.1.1.36. Accessed January 7, 2019.

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[17] ACGME Common Program Requirements, effective July 1, 2017. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf. Accessed September 14, 2018

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-19)

Introduced by: Virginia, American Association of Clinical Urologists, Louisiana, Mississippi

Subject: American Board of Medical Specialties Advertising

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The American Board of Medical Specialties (ABMS) has an advertising campaign to the general public directing patients to ABMS board certified physicians; and

Whereas, Fees for board certification, recertification, and maintenance of certification amount to thousands of dollars paid by physicians during their professional career in order to practice medicine; and

Whereas, This advertising campaign benefits mainly the ABMS and their component boards; therefore be it

RESOLVED, That our American Medical Association oppose the use of any physician fees, dues, etc., for any advertising by the American Board of Medical Specialties or any of their component boards to the general public. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 02/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-19)

Introduced by: American Association of Public Health Physicians

Subject: The Climate Change Lecture for US Medical Schools

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, AMA policy recognizes the grave and urgent risks to human health posed by global climate change and "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" (AMA Policy H-135.938); and

Whereas, Experts have stated that, "climate change and health education should be rapidly integrated into U.S. health professional curricula and continuing medical education" but medical schools have been slow to proceed because there is not a broad consensus as to what information to include, how to add this to the curriculum, and what information might be displaced if climate change were added[1]; and

Whereas, The Global Consortium on Climate and Health Education published in March 2018 the paper "Climate and Health Core Competencies", an institutional guide to climate change educational content for medical schools, which supports adding topics of climate change into medical school curricula[2]; and

Whereas, The AMA is uniquely positioned to influence accreditation bodies and medical schools to introduce quickly a minimum standard of climate change education for all medical students; therefore be it

RESOLVED, That our American Medical Association recommend that one hour of teaching on climate change, "The Climate Change Lecture", be required for all medical students before graduation with the M.D. or D.O. degree as a minimum standard, with more than one hour of teaching encouraged for medical schools that so choose (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend that the goals of "The Climate Change Lecture" be for medical students upon graduation to have a basic knowledge of the science of climate change, to be able to describe the risks that climate change poses to human health, and be prepared to advise patients how to protect themselves from the health risks posed by climate change (Directive to Take Action); and be it further

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[1] http://www.lancetcountdown.org/media/1426/2018-lancet-countdown-policy-brief-usa.pdf (Accessed Feb. 17, 2019)
[2] Columbia University Mailman School of Public Health: Global Consortium on Climate and Health Education. GCCHE Core Climate & Health Competencies for Health Professionals [Internet]. 2018. Available from: https://www.mailman.columbia.edu/research/global-consortium-climate-and-health-education/mission

RESOLVED, That our AMA recommend that medical schools be exempted from the requirement of "The Climate Change Lecture" that have already implemented pedagogy on this topic that amounts to an hour or more of required learning on climate change and health for medical students (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare a prototype PowerPoint slide presentation and lecture notes for "The Climate Change Lecture", which could be used by medical schools, or schools may create their own lecture, video or online course to fulfill the requirements of "The Climate Change Lecture" (Directive to Take Action); and be it further

RESOLVED, That our AMA write to the Commission on Osteopathic College Accreditation (COCA) which is the accrediting organization for schools offering the D.O. degree in the United States; to the Liaison Committee on Medical Education (LCME), which is the accrediting organization for schools offering the M.D. degree in the United States (including for the Uniformed Services University of the Health Sciences); and to the LCME representative from the AMA Medical Student Section, to recommend that "The Climate Change Lecture", using AMA's prototype PowerPoint presentation and notes, or other formats, become a requirement for all M.D. and D.O. degrees for United States medical schools beginning with 2021 graduates (Directive to Take Action); and be it further

RESOLVED, That our AMA delegation to the World Medical Association present a similar resolution to the World Medical Association recommending the concept of the "The Climate Change Lecture" for medical schools worldwide. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $50,000.

Received: 04/30/19

Other Resources:

"My Patients' Health Depends on Addressing Climate Change" By Autumn Vogel (4th Year medical school student Penn State Med School) February 6, 2019 https://otherwords.org/im-a-future-physician-my-patients-health-depends-on-addressing-climate-change/ Accessed February 17, 2019.

"Preparing Medical Students for a Warmer World" By Christian Cayon (medical student at Mt. Sinai School of Medicine) January 03, 2019 https://www.truthdig.com/articles/the-looming-health-crisis-we-arent-preparing-for/ Accessed February 17, 2019.

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
Citation: (CSAPH Rep. 3, I-08; Reaffirmation A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-19)

Introduced by: California

Subject: Graduate Medical Education and the Corporate Practice of Medicine

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Many states have policies and laws intended to prevent unlicensed persons from interfering with or influencing a physician's professional judgment; and

Whereas, At least 38 states have laws that prohibit lay entities from owning or operating medical practices; and

Whereas, The education of residents and fellows is a matter of the highest importance and the foundation of medical education in the United States; and

Whereas, The environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; and

Whereas, A growing number of Emergency Medicine residency and fellowship training programs are operated by incorporated lay entities; and

Whereas, Corporate-owned lay entities who manage emergency departments and residency programs can be found nationwide with at least 14 programs currently in Florida, Georgia, Pennsylvania, Ohio, Michigan, West Virginia, Illinois, Nevada, Texas, and Oklahoma; and

Whereas, These same corporate-owned lay entities also sponsor a growing number of graduate medical education (GME) programs in other specialties including Internal Medicine and Anesthesiology; and

Whereas, The AMA currently has no policy relating to the ownership by corporate-owned lay entities of GME training programs; therefore be it

RESOLVED, That our American Medical Association recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs (New HOD Policy); and be it further

RESOLVED, That our AMA support that the Accreditation Council for Graduate Medical Education require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 04/29/19

RELEVANT AMA POLICY

Accounting for GME Funding D-305.992
Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education.
Citation: (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-19)

Introduced by: California

Subject: Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, In 2015, only 7% of California's graduating MDs and 4% of graduating DOs were Latino compared to 38% of the state's population, and 5% and 1% of graduating MD's and DO's were African-American, compared to 6% of the state's population (Toretsky); and

Whereas, Nationally, only 5% of southeast Asians are likely to apply to medical schools, even less than 8% of African American and 6% of Latino individuals; and

Whereas, According to the Office of Minority Health, health inequities experienced by minority communities are often exacerbated by the lack of underrepresented minorities working as professionals in health and biomedical science fields; and

Whereas, Lack of ethnic diversity among the nation's physicians may exacerbate the existing physician shortage for underserved communities as ethnic minority physicians are more likely than their White counterparts to practice in those communities (Grumbach); and

Whereas, Intensive academic advising and one-on-one faculty mentoring are important components of pipeline programs that can meet and overcome structural, institutional, academic, and personal challenges (Kuo); and

Whereas, A diverse physician workforce will require the continuing attention of medical school leadership and health care systems and interventions to provide opportunities for diverse physicians to join the leadership ranks (Center); and

Whereas, AMA has supported pipeline programs and intervention programs designed to increase ethnic minority physicians in medically underserved areas; and

Whereas, To date, there has been no comprehensive database tracking health pipeline program participants and the achievement of their desired goals; and

Whereas, What limited data that does exist shows health and biomedical science pipeline programs desire the ability to recognize, promote and share best practices and seek more centralized communication between programs; therefore be it

RESOLVED, That our American Medical Association support the publication of a white paper chronicling health care career pipeline programs across the nation aimed at increasing the number programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/29/19

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-19)

Introduced by: Illinois

Subject: Lack of Support for Maintenance of Certification

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The American Board of Medical Specialties (ABMS) has responded to a groundswell of criticism focused on the requirements for maintenance of certification (MOC) by creating an independent "Vision Commission" designed to "reimagine a system of continuing certification"; and

Whereas, The Vision Commission released its draft report December 11, 2018, with a public comment period that ended January 15, 2019; and

Whereas, The draft report was divided into "Findings" and "Recommendations," and some of the highlights include results of a survey conducted by the Vision Commission which showed that only 12% of 34,616 physicians surveyed valued the program; and

Whereas, Robust evidence does not exist correlating physicians' grades on secure, pass/fail MOC exams with patient outcomes; and

Whereas, Secure exam questions and assessments that rely exclusively on knowledge recall are not aligned with how diplomates practice and provide patient care; and

Whereas, The Vision Commission has documented significant harmful consequences of MOC, stating "The Commission heard compelling testimony from all stakeholders that loss of certification can lead to loss of employment or certain employment opportunities for diplomates or loss of reimbursement from insurance carriers"; and

Whereas, One of the promises in the Hippocratic Oath we take as physicians is "First, do no Harm" or "primum non nocere"; therefore be it

RESOLVED, That our American Medical Association urge all American Board of Medical Specialties (ABMS) Boards to phase out the use of mandated, periodic, pass/fail, point-in-time examinations, and Quality Improvement/Practice Improvement components of the Maintenance of Certification process, and replace them with more longitudinal and formative assessment strategies that provide feedback for continuous learning and improvement and support a physician's commitment to ongoing professional development (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage all ABMS Boards to adopt and immediately begin the process of implementing the following recommendation from the Continuing Board Certification Vision For the Future Commission Final Report: “Continuing certification must change to incorporate longitudinal and other innovative formative assessment strategies that support learning, identify knowledge and skills gaps, and help diplomates stay current. The ABMS Boards must offer an alternative to burdensome highly-secure, point-in-time examinations of knowledge.” (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

The topic of this resolution is currently under study by the Council on Medical Education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-19)

Introduced by: Illinois

Subject: Interest Rates and Medical Education

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The average medical student will graduate two hundred to three hundred thousand dollars in debt ("Medical Student Education," 2017; Bavier, 2016); and

Whereas, Almost 90% of Illinois medical students pay for medical education using federal grants (Smith et al., 2018); and

Whereas, The current interest rates for professional student loans from the federal government are 6.6 - 7.6% ("Interest Rates", 2018); and

Whereas, The median and mean 10-year US Treasury Rates are 3.85% and 4.56%, respectively ("10 Year Treasury Rate", 2018); and

Whereas, Interest can result itself in a large financial burden and discourage the entry of economically disadvantaged applicants (Fruen, 1983); and

Whereas, The federal government should invest in the education and training of healthcare providers, not profit from it; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt." (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

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RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. 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.
5. Encourage the National Health Service 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.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. 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.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in 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; (i) 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.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-19)

Introduced by: New York

Subject: Mental Health Services for Medical Students

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Medical students have a higher rate of depression, burnout, and suicidal ideation than the general population; and

Whereas, The Association of American Medical Colleges' recommendations regarding health services for medical students includes giving all students access to confidential counseling by mental health professionals as well as keeping records confidential; and

Whereas, The lack of resources often keep schools from implementing these recommendations; and

Whereas, There is significant concern regarding the stigma of mental illness among medical students who may benefit from mental health services; and

Whereas, Demanding schedules, cost and stigma interfere with access to treatment; therefore be it

RESOLVED, That our American Medical Association recommend that the Association of American Medical Colleges strengthen their recommendations to all medical schools that medical schools provide confidential in-house mental health services at no cost to students, without billing health insurance, and that they set up programs to educate both students and staff about burnout, depression, and suicide. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-19)

Introduced by: New York

Subject: Maintenance of Certification Moratorium

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Many physicians find elements of Continuous Certification/Maintenance of Certification (MOC) problematic; and

Whereas, Elements of MOC do not reflect the manner in which medicine is practiced; and

Whereas, Endless certification has become another element which contributes to physician stress and burnout; and

Whereas, MOC has harmed physicians--physically, emotionally, and economically; and

Whereas, Boards have reaped wealth at the expense of their diplomates; and

Whereas, Other professions require continuing education and professionalism, but none require secure examinations or "knowledge check-ins;" and

Whereas, The draft report of the Vision Initiative has found these issues and more; and

Whereas, The American College of Physicians, the National Board of Physicians and Surgeons, and the American Association of Plastic Surgeons and many state societies have all commented on the problematic state of MOC; therefore be it

RESOLVED, That our American Medical Association call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice Improvement (PI) components of Maintenance of Certification (MOC) (Directive to Take Action); and be it further

RESOLVED, That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only (Directive to Take Action); and be it further

RESOLVED, That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

The topic of this resolution is currently under study by the Council on Medical Education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-19)

Introduced by: New York

Subject: Promoting Addiction Medicine During a Time of Crisis

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The ongoing opioid crisis persists with statistics showing that overdose deaths remain prevalent despite quantity limits, prescription monitoring programs, and mandatory physician education; and

Whereas, The expense of this problem is growing with its devastating toll on those with substance use disorders and their families; and

Whereas, Medication assisted treatment programs have become perceived as the most successful intervention; and

Whereas, Most medical students we encounter state that they have very little exposure to the current protocols and management and admit that this is inadequately covered in current medical education; and

Whereas, Recently the American Board of Preventive Medicine under the American Board of Medical Specialties has taken over the credentialing and administering the path to board certification, in essence, legitimizing it as a recognized medical subspecialty; and

Whereas, Addiction medicine science includes, but is not limited to: history of drug abuse, genetics pharmacology, epidemiology, medical evaluation and management, treatment settings, behavioral health methodologies, toxicology, covering all substances, e.g. opiates, alcohol, nicotine, stimulants, hallucinogens; therefore be it

RESOLVED, That our American Medical Association endorse and support the incorporation of addiction medicine science into medical student education and residency training (New HOD Policy); and be it further

RESOLVED, That our AMA transmit this resolution to the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education (ACGME). (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-19)

Introduced by: New York

Subject: Mental Health Care for Medical Students

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Prior to matriculating, medical students have been shown to have lower rates of burnout and depression than the general population[1], but active medical students are more likely to show symptoms of depression and fatigue than the general population;[2] and

Whereas, In the United States, the prevalence of clinical depression in first year medical students is greater than one in three students yet less than 15% of depressed medical students seek treatment;[3] and

Whereas, Approximately 50% of medical students report burnout, and over 10% report suicidal ideation;[4] and

Whereas, Stigma and barriers relating to self-perception and perception by others are higher in medical students than in the general population with regards to mental health treatment;[5] and

Whereas, Financial and scheduling barriers often limit medical students' utilization of mental health providers recommended by students' medical schools;[6] and

Whereas, Physician well-being has been correlated with physician empathy, communication skills, and critical reflection on practice methods,[7] thus impacting patients as well as physicians; and

Whereas, The Medical Society of the State of New York acknowledges the reality of burnout and depression in physicians and supports measures to mitigate these issues, yet does not address the low utilization of mental health services by medical students; and

Whereas, Opt-out models for mental health resources in residents have shown higher utilization rates than traditional opt-in models;[8] therefore be it

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[1] Brazeau CM, Shanafelt T, Durning SJ, Massie FS, Eacker A, Moutier C, Satele DV, Sloan JA, Dyrbye LN. Distress among matriculating medical students relative to the general population. *Acad Med* 2014;89(11):1520-1525.
[2] Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, Shanafelt TD. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med* 2014;89(3):443-451.
[3] Puthran R, Zhang MW, Tam WW, Ho RC. Prevalence of depression amongst medical students: a meta-analysis. *Med Educ* 2016;50(4):456-468.
[4] Dyrbye LN, Thomas MR, Massie FS, Power DV, Eacker A, Harper W, Durning S, Moutier C, Szydlo DW, Novotny PJ, Sloan JA, Shanafelt TD. Burnout and suicidal ideation among U.S. medical students. *Ann Intern Med* 2008;149:334-341.
[5] Schwenk TL, Davis L, Wimsatt LA. Depression, stigma, and suicidal ideation in medical students. *JAMA* 2010;304:1181-1190.
[6] Karp JF, Levine AS. Mental health services for medical students—time to act. *N Engl J Med*. 2018;379:1196-1198.
[7] Neumann M, Edelhauser F, Tauschel D, et al. Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Acad Med* 2011;86(8):996-1009.
[8] Sofka S, Grey C, Lerfald N, Davisson L, Howsare J. Implementing a Universal Well-Being Assessment to Mitigate Barriers to Resident Utilization of Mental Health Resources. *J Grad Med Educ* 2018;10(1):63-66.

RESOLVED, That our American Medical Association encourage all medical schools to assign a mental health provider to every incoming medical student (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all medical schools to provide an easy way for medical students to select a different provider at any time (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all medical schools to require each student's mental health professional or related staff to contact the student once per semester to ask if the student would like to meet with their mental health professional, unless the student already has an appointment to do so or has asked not to be contacted with regards to mental health appointments (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all medical schools to provide an easy process for students to initiate treatment with school mental health professionals at no cost to the student or professional from the mental health community at affordable cost to the student, and without undue bureaucratic burden. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-19)

Introduced by: International Medical Graduates Section

Subject: Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, IMGs in the past were permitted to work in academic institutions, either for their specific skills or a need due to fill unmet patient care needs in certain physician specialties or geographical areas; and

Whereas, Physicians were allowed to work with an institutional or faculty temporary license granted by their local state medical board without having completed the USMLE examination, or without being American Board certified or eligible in their specialty; and

Whereas, These physicians completed medical school and specialty training abroad were often excellent candidates with strong curricula and their titles were recognized equivalent to the ones received in the U.S. by the receiving academic institution to allow them to work; and

Whereas, In recent years, these physicians faced the problem that many academic and non-academic institutions created rules to have only American Board certified physicians among their faculty/staff and were unwilling to grant institutional licenses any longer which creates a dramatic situation for these physicians who have practiced and trained U.S. medical students, residents and physicians in the U.S. for many years; and

Whereas, These IMGs admitted to work in the U.S. to fill a void and a need are now faced with losing their jobs without the ability to practice anywhere in the U.S.; and

Whereas, in the Commonwealth of Pennsylvania, an IMG or graduate of an unaccredited medical college may have their unmet qualifications waived by the Board if the applicant is determined to possess the educational background and technical skills and the waiver is considered to be beneficial to patients and the community; therefore be it

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (*AMA PRA Category 1 Credit*", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19.The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in MOC.
27.Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-19)

Introduced by: International Medical Graduates Section

Subject: Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, By 2030, demand for physicians will exceed supply by a range of 42,600 and 121,300. The lower estimate would represent more aggressive changes in care delivery patterns subsequent to the rapid growth in non-physician clinicians and widespread delayed retirement by currently practicing physicians;[1] and

Whereas, In 2025, largely resulting from the aging and growth of the U.S. population, the greater increase in demand compared with supply will result in a projected deficit of 23,640 FTE primary care physicians nationally[2]; and

Whereas, A shortfall of between 14,800 and 49,300 primary care physicians will persist despite a moderate increase in the use of advanced practice nurses (APRNs) and physician assistants (PAs); and

Whereas, A total of 7,826 active ECFMG applicants did not match in 2019[6]. In 2018, out of 43,909 registrants and 37,103 active applicants, only 32,967 got in to a residency position leading to a total of 10,942 unmatched medical graduates who registered on the National Residency Matching Program (NRMP) website which includes 4,136 unmatched active applicants; and

Whereas, Working as APRN or PA is not an option for these physicians because this would require going back to school and obtaining a different degree at a very high financial cost and also wasting years of education and millions of dollars in school debt, despite meeting the standard of qualifications necessary to practice medicine;[3] and

Whereas, Missouri, Kansas, and Arkansas have passed laws to allow unmatched graduates to work in medically underserved areas without doing a residency under the supervision of a licensed physician[4]. Their work is considered equivalent to that of a physician assistant for regulations of the Centers for Medicare and Medicaid Services (CMS) and those physicians can get credit towards their residency training as in Utah; and

Whereas, Other countries like the European Union allows physicians to practice as general practitioners after validation of the title by an accreditation body[5]. A medical graduate cannot practice medicine in the United States without at least one year of postgraduate residency; therefore be it

RESOLVED, That our American Medical Association advocate for the state medical boards to accept medical graduates who have passed USMLE Steps 1 and 2 as their criterion for limited license, thus using the existing physician workforce of trained and certified physicians in the primary care field and allowing them to get some credit towards their residency training as is being contemplated in Utah (Directive to Take Action); and be it further

RESOLVED, That our AMA work with regulatory, licensing, medical, and educational entities dealing with physician workforce issues: the American Board of Medical Specialties, the Association of American Medical Colleges (AAMC), the Association for Hospital Medical Education, Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards, and the National Medical Association work together to integrate unmatched physicians in the primary care workforce in order to address the projected physician shortage. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:
1 New research shows increasing physician shortages in both primary and specialty care
https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/
2 Projecting the Supply and Demand for Primary Care Practitioners Through 2020
https://bhw.hrsa.gov/health-workforce-analysis/primary-care-2020
3 International Medical Graduates in the US Physician Workforce
https://jaoa.org/article.aspx?articleid=2213422
4 Looming question for medical students: Will they be shut out of advanced training?
5 https://www.statnews.com/2016/03/17/medical-students-match-day/
6 https://euraxess.ec.europa.eu/spain/what-procedure-recognition-or-equivalence-foreign-university-qualification
Main Residency Match Data and Reports http://www.nrmp.org/main-residency-match-data/

RELEVANT AMA POLICY

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
1. It is AMA policy that:
A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.
Policy Timeline
CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16

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.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-19)

Introduced by: Resident and Fellow Section

Subject: Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Laboratory tests are the single highest volume medical activity that is vital for diagnostic and therapeutic decisions and patient care and often leads to additional downstream interventions and costly care[1,2]; and

Whereas, Medical errors including inappropriate use of laboratory tests are the third leading cause of death in the United States and lead to preventable morbidity and mortality[3,4]; and

Whereas, Appropriate laboratory test utilization can reduce healthcare costs and improve quality of care[5]; and

Whereas, The Centers for Disease Control and Prevention and other studies have found that poor knowledge and inappropriate use of laboratory tests by physicians is due in part to the lack of formal training during medical school[6-8]; and

Whereas, The Institute of Medicine supports enhanced training in diagnostic processes for healthcare professionals[9]; and

Whereas, The clinical applications of pathology and laboratory medicine are not a required clerkship in nearly half of all medical schools in the United States or are fragmented and poorly integrated into medical school curriculums[10-13]; and

Whereas, One third of medical school program directors express concern about the inadequate understanding of pathophysiology concepts by medical students[14]; and

Whereas, Consensus guidelines for clinical competencies and education in pathology and laboratory medicine have been established and recommended by the Association of Pathology Chairs and other leading pathologists in academic institutions and organizations[7,15-19]; therefore be it

RESOLVED, That our American Medical Association study current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

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RELEVANT AMA POLICY

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.
2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.
3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16

Patient Safety Curricula in Undergraduate Medical Education D-295.942

1. Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient safety and quality improvement issues in medical school curricula.
2. Our AMA will encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medial students.

Citation: (Res. 801, I-07; Appended: Res. 320, A-12

Voluntary Health Care Cost Containment H-155.998
(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.
Citation: (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes.
Citation: Sub. Res. 301, A-13; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17

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.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.
Citation: CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17; Appended: Res. 961, I-18

Resident Education in Laboratory Utilization H-310.960
Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care.
Citation: (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11

Improving Genetic Testing and Counseling Services H-480.944
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.
Citation: Res. 913, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-19)

Introduced by: Resident and Fellow Section

Subject: Evaluation of Changes to Residency and Fellowship Application and Matching Processes

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The Association of American Medical Colleges (AAMC) is currently piloting a new, mandatory Standardized Video Interview (SVI) for students applying to emergency medicine residency programs[1]; and

Whereas, The SVI requires students to provide video-taped responses to six questions intended to evaluate a student's professionalism and interpersonal/communication skills, each displayed for 30 seconds, and have as many as 3 minutes to respond to each question[2]; and

Whereas, During the pilot, videos will be scored by third-party trained raters, yet the AAMC expects that human review would likely be replaced by computer-based analysis should the SVI expand to other specialties[3]; and

Whereas, The AAMC has yet to demonstrate that computer-based analysis of video-responses is non-inferior to human rating; and

Whereas, The AAMC working group that evaluated the voluntary pilot did not include medical students; and

Whereas, The AAMC reports that the research pilot showed that the SVI "measures something different than academic competency," but was unable to demonstrate correlation between SVI scores and residency placement, performance in residency or performance in the target competencies[4]; and

Whereas, The AAMC has not provided any estimate of costs or information regarding who would pay for this program should the SVI continue beyond its operational pilot; and

Whereas, No data is available to demonstrate that the SVI will not discriminate against underrepresented minority (URM), LGBTQ, non-native English speakers and other students who may be adversely affected by implicit bias during the residency application process; therefore be it

RESOLVED, That our American Medical Association support proposed changes to residency and fellowship application requirements only when (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds; and (4) the costs to medical students and residents are mitigated (New HOD Policy): and be it further

RESOLVED, That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met (New HOD Policy); and be it further

RESOLVED, That our AMA continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1 AAMC Standardized Video Interview. https://students-residents.aamc.org/applying-residency/article/aamc-standardized-video-interview-research-study/. Published April 3, 2017. Accessed September 7, 2017.
2 AAMC Standardized Video Interview Frequently Asked Questions. AAMC Students, Applicants and Residents. https://students-residents.aamc.org/attending-medical-school/article/aamc-standardized-video-interview-faqs/. Published April 3, 2017. Accessed September 4, 2017.
3 AAMC Standardized Video Interview Update. https://aamc-orange.global.ssl.fastly.net/production/media/filer_public/c7/6f/c76f2e9f-ccd4-428e-9710-e9bdcea2a9d0/standardized_video_interview_summary_2017_gsa.pdf. Published May 2017.
4 Standardized Video Interview Update for Applicants Webinar. AAMC Students, Applicants and Residents. https://students-residents.aamc.org/video/svi-update-applicants-webinar/?edit_off. Published June 6, 2017. Accessed September 5, 2017.

RELEVANT AMA POLICY

Clinical Skills Assessment During Medical School D-295.988
1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.
5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.
6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.
7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.
Citation: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 09, A-17

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

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.
Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17

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.
Citation: (Res. 606, A-14)

Educating Competent and Caring Health Professionals H-295.975
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.
(3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.
(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.
Citation: BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: CME Rep. 01, A-17

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18

Residency Interview Costs H-310.966
1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.
Citation: (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15

Residency Interview Schedules H-310.998
Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.
Citation: (Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07; Modified: Res. 302, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-19)

Introduced by: Resident and Fellow Section

Subject: Scholarly Activity by Resident and Fellow Physicians

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The current requirements for scholarly activity for resident physicians vary between medical specialties and there is no uniform definition; and

Whereas, The current Accreditation Council for Graduate Medical Education (ACGME) common program requirement for scholarly activity are broad and non-specific only stating that residents "should participate in scholarly activity"; and

Whereas, There are many ways to teach an understanding of research methods, including literature review in the form of journal clubs, lectures, and small group discussions of research methods; and

Whereas, The completion of a research project only educates the participant on one form of research methodology; and

Whereas, Seventy-five percent of the physicians who complete residency do not go on to pursue careers in academic medicine[1] and thus gain little experience relevant to their future careers from the mandatory completion of a research project; and

Whereas, This percentage is not different when emergency medicine residency programs that require research are compared to programs that do not require research[2]; and

Whereas, Boyer's model for scholarship was proposed for inclusion as part of the ACGME Common Program Requirements currently under revision, which emphasize that scholarly activity includes a wide variety of modalities, including discovery, integration, application, and teaching[3]; and

Whereas, Boyer's model of scholarship application involves problem solving and putting into practice the discoveries from research[3], not unlike the work done within national organizations such as the AMA; and

Whereas, Faculty in almost all medical and surgical specialties are allowed to use their national leadership experience within the AMA or specialty specific organizations as part of their

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[1] AAMC. "Report of Residents: Table C7. Full-Time Faculty-Appointment Status at U.S. Medical Schools for Residents Who Completed Residencies, by Specialty." Published December 2017. Accessed April 9, 2018. Available at https://www.aamc.org/data/484734/report-on-residents-2017-c7table.html.

[2] Geyer B, Kaji A, Katz E, et.al. (2015) "A National Evaluation of the Scholarly Activity Requirement in Residency Programs: A Survey of Emergency Medicine Program Directors." *Academic Emergency Medicine*. 22:11. 1337-44.

[3] Boyer E. (1990). *Scholarship Reconsidered: Priorities of the Professoriate*. Carnegie Foundation for the Advancement of Teaching. Accessed April 9, 2018. Available at https://depts.washington.edu/gs630/Spring/Boyer.pdf.

scholarly requirements[4] but trainees in those same specialties are not allowed to use that same national committee experience for the purpose of completing scholarly activity requirements[5]; and

Whereas, Proposed changes to the ACGME Common Program Requirements may still allow specialty-specific Review Committees to narrowly define scholarly activity as peer-reviewed publication only[6]; therefore be it

RESOLVED, That our American Medical Association define resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity (New HOD Policy); and be it further

RESOLVED, That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Principles for Graduate Medical Education H-310.929
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

[4] ACGME. "Specialty-specific References for DIOs: Faculty Scholarly Activity ACGME." September 2017. Internet. Accessed April 9, 2018. https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Faculty.pdf.
[5] ACGME. "Specialty-specific References for DIOs: Resident/Fellow Scholarly Activity ACGME." September 2017. Internet. Accessed April 9, 2018. https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Resident-Fellow.pdf.
[6] ACGME. "ACGME Common Program Requirements (Residency) Sections I-V." Published 6 February 2018. Accessed April 2018. Available at http://www.acgme.org/Portals/0/PFAssets/ReviewandComment/CPR-Residency-2018-02-06-R&C.pdf.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the “Program Requirements.” The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution’s GME Committee must monitor programs’ supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate

to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-19)

Introduced by: Senior Physicians Section

Subject: Medical Student Debt

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, There is a marked increase in the senior patient population, as approximately 10,000 people turn 65 years of age each day[1]; and

Whereas, There is a current shortage of primary care physicians which will have a major impact on caring for the marked increase in senior patients; and

Whereas, The incidence of chronic disease in the aging population is expected to generate an increased need for primary care physicians, with deficits of 35,000-40,000 adult generalists projected by 2025[2]; and

Whereas, Three-quarters of medical school students graduated with debt in 2017, reporting a median debt amount of $192,000[3]; and

Whereas, Medical student debt is continuing to influence primary care specialty choice, with only a third of medical school graduates planning to practice in the primary care specialties of internal medicine, family medicine and pediatrics[2]; and

Whereas, There is a growing gap between the racial, ethnic and socioeconomic makeup of medical school classes and that of the general population, further pushing medical education out of reach for many poor and minority students[4]; and

Whereas, Multiple top tier medical schools including Kaiser Permanente and New York University plan to cover tuition for all current and future students as they recognize the increasing debt burden on young people who aspire to become physicians[5]; and

Whereas, The association among debt, specialty choice and income needs to be further examined to determine whether or not debt is a determinant of specialty choice or future income; and

Whereas, New models may help shape policies to better match the needs of society and to the aspirations of students who want to become physicians; and

Whereas, The AMA could convene medical schools to look at new approaches to examine to what extent these new schools have a common vision and approach to undergraduate medical education, and to spur other top medical schools to follow suit; therefore be it

RESOLVED, That our American Medical Association formulate a task force to look at undergraduate medical education training as it relates to specialty choice, and develop new polices and novel approaches to prevent debt from influencing primary care specialty choice. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:
1 Russell H. Baby Boomers Retire, Fact Tank, Pew Research Center, December 29, 2010, http://www.pewresearch.org/facttank/2010/12/29/baby-boomers-retire/ (accessed March 4, 2019).
2 Hsu, A.L. & Caverzagie, K. Educational Debt and Specialty Choice, Virtual Mentor. AMA Journal of Ethics, 2013;15(7):615-619. https://journalofethics.ama-assn.org/article/educational-debt-and-specialty-choice/2013-07 (accessed March 4, 2019).
3 The Association of American Medical Colleges An Updated Look at Attendance Cost and Medical Student Debt at U.S. Medical Schools, AAMC, Volume 17, Number 1, August 2017.
https://www.aamc.org/download/482236/data/august2017anupdatedlookatattendancecostandmedicalstudentdebtatu.pdf (accessed March 4, 2019).
4Talamantes, E., Henderson, M., Fancher, T. & Mullan, F. Closing the Gap – Making Medical School Admissions More Equitable. N Engl J Med 2019; 380:803-805. https://www.nejm.org/doi/full/10.1056/NEJMp1808582?query=TOC (accessed March 4, 2019).
5 Goodnough, A. Kaiser Permanente's New Medical School Will Waive Tuition for Its First 5 Classes, The New York Times. February 19, 2019,
https://www.nytimes.com/2019/02/19/health/kaiser-medical-school-free-.html (accessed March 4, 2019).

RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs—such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector—to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. 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.
5. Encourage the National Health Service 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.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. 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.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO

programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the

contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in 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; (i) 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.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
Citation: CME Report 05, I-18; Appended: Res. 953, I-18

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.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-19)

Introduced by: Resident and Fellow Section

Subject: A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Section 504 of the Rehabilitation Act of 1973 states that individuals with disabilities should not "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance[1];" and

Whereas, The Association of American Medical Colleges (AAMC) published guidelines for technical standards (TS) in 1979 in response to Section 504 of the Rehabilitation Act of 1973[2] which called for "certain minimal technical standards for physicians that must be examined and enforced in the admissions process" and placed an emphasis on the MD degree encompassing "a broad undifferentiated degree attesting to the acquisition of general knowledge in all fields of medicine and the basic skills requisite for the practice of medicine"[3,4]; and

Whereas, The above stated TS often emphasize sensorimotor over cognitive abilities, which therefore serve as a barrier for matriculation of students with disabilities[5] with research supporting this claim[6]; and

Whereas, The Americans with Disabilities Act of 1990 (ADA) prohibits institutions of higher education from discriminating against a qualified person on the basis of disability in admission or recruitment and requires entities that must comply with the law to make reasonable accommodations in order to afford an otherwise qualified applicant an equal opportunity to participate in institution's programs[7,8]; and

Whereas, Despite passage of the ADA, parity has not been realized for people with disabilities hopeful of starting a career in medicine as demonstrated by the fact that 19 percent of America's noninstitutionalized population has a disability[9] compared to 1 percent of medical

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[1] Section 504 of the Rehabilitation Act of 1973 - Disability Rights Education & Defense Fund. https://dredf.org/legal-advocacy/laws/section-504-of-the-rehabilitation-act-of-1973/. Accessed January 21, 2018.
[2] Association of American Medical Colleges. Report of the Special Advisory Panel on Technical Standards for Medical School Admission. *Assoc Am Med Coll*. 1979;Washington.
[3] Association of American Medical Colleges. 4.
[4] Association of American Medical Colleges. 5.
[5] Wainapel, F. S. Unjustified Barriers for Medical School Applicants with Physical Disabilities - American Medical Association Journal of Ethics (formerly Virtual Mentor). *Virtual Mentor*. 2015;17(2):160. doi:10.1001/VIRTUALMENTOR.2015.17.2.PFOR2-1502.
[6] Zazove P, Case B, Moreland C, et al. U.S. Medical Schools' Compliance With the Americans With Disabilities Act. *Acad Med*. 2016;91(7):979-986. doi:10.1097/ACM.0000000000001087.
[7] 42 U.S. Code § 12182 - Prohibition of discrimination by public accommodations | US Law | LII / Legal Information Institute. https://www.law.cornell.edu/uscode/text/42/12182. Accessed January 21, 2018.
[8] McKee M, Case B, Fausone M, Zazove P, Ouellette, Fetters and MD. Medical Schools' Willingness toAccommodate Medical Students with Sensory and Physical Disabilities: Ethical Foundations of a Functional Challenge to "Organic" Technical Standards. *AMA J Ethic*. 2016;18(10):993-1002. oi:10.1001/journalofethics.2016.18.10.medu1-1610.
[9] Brault MW. Americans with Disabilities: 2010. 2012. https://www.census.gov/newsroom/cspan/disability/20120726_cspan_disability_slides.pdf. Accessed January 21, 2018.

students[6] and 2-10 percent of practicing physicians[10] although technical accommodations are widely available and used; and

Whereas, The majority of US medical schools' and residencies' TS do not explicitly support accommodating disabilities and furthermore "do not support provision of reasonable accommodations for students with disabilities as intended by the ADA" thus precluding individuals with disabilities from enrolling[6]; and

Whereas, TS uphold the largely unspoken standard of the "undifferentiated physician"--meaning all students graduating from medical school should be able to enter any medical specialty--though this is an unrealistic expectation for even students without disabilities and therefore rejecting students with disabilities based on limitations that would qualify them as unfit for certain specialties is an unjustified exclusion[5,11]; and

Whereas, The majority of US medical schools' and residencies' TS require students to demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance, therefore, highlighting the students' limitations[6,8] and have not been revised since their original form in 1979; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.
Citation: Res. 220, I-17

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,

[10] DeLisa JA, Thomas P. Physicians with disabilities and the physician workforce: a need to reassess our policies. *Am J Phys Med Rehabil*. 2005;84(1):5-11. http://www.ncbi.nlm.nih.gov/pubmed/15632483. Accessed January 21, 2018.
[11] Hartman DW, Hartman CW. Disabled students and medical school admissions. *Arch Phys Med Rehabil*. 1981;62(2):90-91. http://www.ncbi.nlm.nih.gov/pubmed/6453567. Accessed January 21, 2018.

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.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

9.5.4 Civil Rights & Medical Professionals
Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.
AMA Principles of Medical Ethics: IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-19)

Introduced by: Iowa

Subject: Rural Health Physician Workforce Disparities

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Rural Americans are older, poorer, and have a higher incidence of disease and disability, increased mortality rates, lower life expectancy, and higher rates of pain and suffering; and

Whereas, Rural health disparities have become greater and the trend is continuing; and

Whereas, Rural Americans make up about 20% of the population, yet only 12% of America's primary care physicians and only 8% of specialty physicians are located in rural areas;[1] and

Whereas, Rural health provider organizations are reporting it is very difficult to recruit and retain providers because of large decreases in their Medicare payment due to Geographic Practice Cost Index (GPCI) adjustments; and

Whereas, GPCI payment adjustments are primarily based on 1) practice expenses (PE) and 2) physician work (PW) value; and

Whereas, The Centers for Medicare Services' (CMS) payment policies penalize rural physicians, while claiming that practice expenses (PE) are much lower--despite the lack of evidence that PE are less in rural areas; and

Whereas, The AMA's own analysis of data from the last nationwide (PPI) survey of practice expenses showed no difference in PE from large metropolitan, small metropolitan, or non-metropolitan areas;[2] and

Whereas, GPCI adjustments for PW have never used data regarding the actual market cost of physician labor (wages) in rural vs. large metropolitan areas--instead CMS has used other occupations as a proxy; and

Whereas, Data sources such as recruiting and locum tenens companies, as well as Doximity's website show that regional market data on physician wages (actual local cost of physician labor) has no relation to CMS' proxy-derived work GPCI index; and

Whereas, The data used by CMS for these PE and PW GPCI adjustments is non-transparent, outdated, inaccurate, and some of the data has never proven to be relevant; therefore be it

RESOLVED, That our American Medical Association undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies to alleviate rural physician workforce shortages. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

References:
[1] Orlowski, J., & Dill, M. (2017). Rural America Faces Shortage of Physicians to Care for Rapidly Aging Population; Aging Today.
[2] Gillis, K. (2009). Physician Practice Expenses by Location. AMA Policy Research Perspectives.
[3] Doximity (2019). Career Navigator: Physician Compensation and Housing Cost Data Trends By County & Specialty.

RELEVANT AMA POLICY

Geographic Practice Cost Index D-400.985
Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.
Citation: (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12; Reaffirmation: I-12; Reaffirmation I-13

Elimination of Payment Differentials Between Urban and Rural Medical Care H-240.971
Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.
Citation: (Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10

Equal Pay for Equal Work D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.
Citation: (BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09

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.
Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18

Access to and Quality of Rural Health Care H-465.997
(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.
Citation: (CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11

Enhancing Rural Physician Practices H-465.981
The AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas's Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; and (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
Citation: CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:
A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
H. 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.
I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18

Rural Health H-465.982
The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.
Citation: (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

Economic Viability of Rural Sole Community Hospitals H-465.979
Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.
Citation: (CMS Rep. 3, A-15

Closing of Small Rural Hospitals H-465.990
Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.
Citation: (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10: Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-19)

Introduced by: Minority Affairs Section

Subject: Adding Pipeline Program Participation Questions to Medical School Applications

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The Association of American Medical Colleges (AAMC) reports that enrollment rates among underrepresented minorities remain significantly low despite a rise in total medical student matriculation rates that exceed 21,000 medical students[1]; and

Whereas, All premed pipeline programs struggle to track former participants and whether they enrolled in medical school; and

Whereas, Without accurate data on the effectiveness and influence of premed pipeline programs on medical school enrollment; and

Whereas, 133 out of 141 American medical schools use the AAMC electronic medical school application (AMCAS), offering an unparalleled opportunity to gather data on pipeline program participation in medical school applicants; therefore be it

RESOLVED, That our American Medical Association collaborate with the Association of American Medical Colleges (AAMC) and other stakeholders to coalesce the data to create a question for the AAMC electronic medical school application to allow applicants to identify previous pipeline program participation to determine the effectiveness of pipeline programs those who are underrepresented in medicine in their decisions to pursue careers in medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA develop a plan to analyze the data once this question is implemented with input from key stakeholders, including AAMC, the Accreditation Council for Graduate Medical Education, and interested medical societies and premed pipeline programs. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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[1] https://www.npr.org/2015/10/24/449893318/there-were-fewer-black-men-in-medical-school-in-2014-than-in-1978);

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.
2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.
3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.
4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18

Diversity in the Physician Workforce and Access to Care D-200.982
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health

Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.
Citation: CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation: A-16

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.
Citation: BOT Rep. 33, A-18

8.5 Disparities in Health Care
Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.
(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
AMA Principles of Medical Ethics: I,IV,VII,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320
(A-19)

Introduced by: Michigan

Subject: Opioid Education in Medical Schools

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, Opioids are attributed to over 47,000 overdose deaths in 2017 according to the Centers for Disease Control and Prevention; and

Whereas, Approximately 130 Americans die every day from an opioid overdose, culminating in nearly 48,000 drug overdose deaths involving an opioid in 2017; and

Whereas, Being the primary source of legally prescribed controlled substances, it is the responsibility of physicians to learn safe, optimal prescribing practices for opioids; and

Whereas, Health professionals, attendings and residents included, often lack the confidence and preparation to approach complex patients who are taking opioids for chronic pain; and

Whereas, It has been shown that some medical school curricula may not adequately spend substantial time covering addiction medicine, or lack emphasis on the complexity of opioid substance use disorder; and

Whereas, There is no current standardized curriculum regarding addiction and drug overdose patient care for Medical Schools; and

Whereas, Prior training initiatives in Medical Schools regarding substance abuse disorders have correlated with significant improvements in students' attitudes, beliefs in role responsibility, and confidence in skills during preclinical years; and

Whereas, The Association of American Medical Colleges created a statement that 74 medical schools signed in order to demonstrate their willingness toward better incorporating opioid-related topics in their training of medical students; and

Whereas, There have been successful implementation of interprofessional education workshops in medical schools that simulate the complex issues of substance use disorder while highlighting the importance of collaborative teamwork; and

Whereas, An eight-hour medication-assisted treatment (MAT) waiver training for medical students is offered by the Providers Clinical Support System, a program funded by the Substance Abuse and Mental Health Services Administration; and

Whereas, Medical schools can partner with the American Society of Addiction Medicine to implement an eight-hour MAT waiver training course for medical students; and

Whereas, The usage of simulated patients and Objective Structured Clinical Exam (OSCE) has shown to increase interviewing and intervention skills, and improve assessment and management skills regarding alcohol and illicit drug abuse; and

Whereas, Studies have shown that up to 50 percent of primary care physicians did not address patients substance abuse, with 40 percent of physicians missed diagnosing a substance use disorder; and

Whereas, Only three percent of primary care physicians in rural areas have received waivers to prescribe buprenorphine to treat opioid use disorder; therefore be it

RESOLVED, That our American Medical Association work with the Liaison Committee on Medical Education to include formalized opioid and related substance use disorder training using an evidence-based multidisciplinary approach in the curriculum of accredited medical schools. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3.Our AMA 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.
Citation: Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15; Appended: Res. 311, A-18

Improving Residency Training in the Treatment of Opioid Dependence H-310.906
Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.
Citation: Res. 301, I-16

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being ?a part of the solution? to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; 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. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA 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. Our AMA 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.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 321
(A-19)

Introduced by: Michigan, North Carolina

Subject: Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, A Physician Health Program is defined as a “confidential resource for physicians, other licensed health care professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions;” and

Whereas, The Physician Health Program (PHP) model represents a system in which physicians with potentially impairing conditions who come forward or are referred are given the opportunity for evaluation, rehabilitation, treatment and monitoring without disciplinary action in an anonymous, confidential and respectful manner; and

Whereas, Ideally, the PHP model is committed to the early identification, evaluation, treatment, monitoring, and earned advocacy, when appropriate, of licensees with potentially impairing qualifying illness(es) prior to the progression to impairment in the workplace; and

Whereas, The PHP model enables effective clinical care for mental, physical and substance abuse disorders, easy access to a variety of clinical interventions and support for those seeking help, including hospitals, families, communities, licensure boards and other components of society and organized medicine; and

Whereas, PHPs, organized medicine, and the respective regulatory entities should work together to advance the principles of collaboration, communication, accountability and transparency to achieve a shared vision of ensuring the health their mutual constituencies while simultaneously ensuring the safety and welfare of patients; and

Whereas, Considering the high costs of recruitment and training, the PHP model can save organizations significant resources for each physician or physician assistant who is retained in, or returned to, practice as the operation of the program, and rehabilitation of health care professionals is more cost effective than the training of new health care professionals; and

Whereas, PHPs operate in 47 states and the District of Columbia; and

Whereas, Physicians can be referred to a PHP by their employer, a colleague, a family member, or even themselves; and

Whereas, PHPs were created with the intention to provide a confidential pathway to rehabilitate and monitor physicians with mental illness, substance use disorders, and other potentially impairing conditions so that they may return safely to the practice of medicine; and

Whereas, In order to earn the confidence, respect, and trust of those they serve, PHPs must be committed to having open lines of communication between all parties involved in carrying out its mission, as well as honest, direct and professional interactions aimed toward common interests; and

Whereas, PHPs must report to the state licensing board any physician suffering from serious psychiatric illness, drug or alcohol use disorders, or any condition it deems to be currently impairing and may place the public at risk if said physician refuses their recommendation for treatment and subsequent disease management; and

Whereas, The Federation of State Medical Boards called for PHPs to develop performance reviews of their programs that demonstrate an ongoing track record of ensuring safety to the public and to reveal deficiencies if they occur, and thus ensure soundness and fairness of practice; and

Whereas, The Federation of State Physician Health Programs (FSPHP) has the stated mission of supporting physician health programs in improving the health of medical professionals, thereby contributing to quality patient care; and

Whereas, The FSPHP strengthens PHPs by promoting best practices and providing guidelines, advocacy, and other resources that enhance their effectiveness. The FSPHP encourages partnerships between physician health programs, regulatory boards, and other appropriate components of organized medicine; and

Whereas, The FSPHP fosters collaboration and engagement with other national and international medical organizations; and

Whereas, The FSPHP opposes discrimination against physicians and the medical community solely based on the presence of a particular diagnosis or other discriminatory factors and supports the use of PHP services in lieu of disciplinary action whenever possible; and

Whereas, The FSPHP supports education and research designed to establish best practices for the prevention, treatment, and monitoring of physicians experiencing substance use disorders, mental illness, physical illness, and other potentially impairing conditions; and

Whereas, The FSPHP's guidelines and philosophy are consistent with the American Medical Association (AMA) Physician Health Program Model ACT https://www.fsphp.org/assets/docs/ama_physicians_health_programs_act_-_2016.pdf; and

Whereas, The FSPHP is currently developing the Performance *Enhancement and Effectiveness Review* (PEER™) program to improve accountability, consistency, and excellence among state PHPs; and

Whereas, The AMA, the American Psychiatric Association, the Accreditation Council of Graduate Medical Education, the American Board of Medical Specialties, the American Osteopathic Association, the American College of Physicians and the FSMB have all sponsored the FSPHP PEER™ process via philosophical, financial, and stated support that reflect a

commitment to further the development of these important programs while at the same time set the stage for appropriate funding for this venture; therefore be it

RESOLVED, That our American Medical Association amend policy D-405.990, "Educating Physicians About Physician Health Programs," by addition to read as follows:

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990
1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; ~~and~~ 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training; and 5) Our AMA will continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; 6) Our AMA will continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

RELEVANT AMA POLICY

Educating Physicians About Physician Health Programs D-405.990
1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.
Citation: (Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12

Impaired Physicians Practice Act H-275.964
Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary.
Citation: (Sub. Res. 7, A-89; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: BOT Rep. 17, I-99; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10

Confidentiality of Enrollment in Physicians (Professional) Health Programs D-405.984
1. Our American Medical Association will work with other medical professional organizations, the Federation of State Medical Boards, the American Board of Medical Specialties, and the Federation of State Physician Health Programs, to seek and/or support rules and regulations or legislation to provide for confidentiality of fully compliant participants in physician (and similar) health programs or their recovery programs in responding to questions on medical practice or licensure applications.
2. Our AMA will work with The Joint Commission, national hospital associations, national health insurer organizations, and the Centers for Medicare and Medicaid Services to avoid questions on their applications that would jeopardize the confidentiality of applicants who are compliant with treatment within professional health programs and who do not constitute a current threat to the care of themselves or their patients.
Citation: (Res. 4, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 322
(A-19)

Introduced by: Medical Student Section

Subject: Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

Whereas, The 8-year graduation rate of U.S allopathic medical students who were not in dual-degree programs was 97.5% for those who matriculated from 2001 to 2010[1]; and

Whereas, Among these students, those who took leaves of absence for reasons other than pursuing a dual degree or for research, the 8-year graduation rate dropped to 69.0–70.4%[1;] and

Whereas, A study of medical students in the state of Michigan found that underrepresented minority students had double the rate of attrition compared to non-underrepresented students, but did not identify causes for the discrepancy[2]; and,

Whereas, Studies in England and Ireland have identified time-points 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 a leave 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 and reasons for which medical students in the United States are most likely to take a leave of absence or withdraw, may assist academic institutions in planning curricular or advising interventions; therefore be it

RESOLVED, That our American Medical Association 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. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

References:
1. Graduation Rates and Attrition Factors for U.S. Medical School Students. AAMC Analysis in Brief. 2014;14(5).
2. Dyrbye LN, Thomas MR, Huschka MM, et al. A Multicenter Study of Burnout, Depression, and Quality of Life in Minority and Nonminority US Medical Students. Mayo Clinic Proceedings. 2006;81(11):1435-1442. doi:10.4065/81.11.1435.
3. Maher BM, Hynes H, Sweeney C, et al. Medical School Attrition-Beyond the Statistics A Ten Year Retrospective Study. BMC Medical Education. 2013;13(1). doi:10.1186/1472-6920-13-13.
4. Yates J. When did they leave, and why? A retrospective case study of attrition on the Nottingham undergraduate medical course. BMC Med Educ. 2012;12:43. doi:10.1186/1472-6920-12-43
5. PubMed search criteria included the following search criteria: (medical student attrition) AND ("2012/01/01"[Date - Publication] : "3000"[Date - Publication])
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 POLICY

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.
Citation: CME Rep. 1, I-98; Reaffirmed: CME Rep. 9, A-07; Reaffirmed: CME Rep. 01, A-17

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.
Citation: Res. 302, A-18

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.
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in

lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18

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.
(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.
(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.
Citation: CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17; Appended: Res. 961, I-18

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.
Citation: Res. 904, I-16

Reference Committee D

BOT Report(s)

11 Policy and Economic Support for Early Child Care

16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients

28 Opposition to Measures that Criminalize Homelessness

29 Improving Safety and Health Code Compliance in School Facilities

CSAPH Report(s)

03 Low Nicotine Product Standard

04 Vector-Borne Diseases

Resolution(s)

401 Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

402 Bullying in the Practice of Medicine

403 White House Initiative on Asian Americans and Pacific Islanders

404 Shade Structures in Public and Private Planning and Zoning Matters

405 Gun Violence Prevention: Safety Features

406 Reduction in Consumption of Processed Meats

407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents

408 Banning Edible Cannabis Products

409 Addressing the Vaping Crisis

410 Reducing Health Disparities Through Education

411 AMA to Analyze Benefits / Harms of Legalization of Marijuana

412 Regulating Liquid Nicotine and E-Cigarettes

413 End the Epidemic of HIV Nationally

414 Patient Medical Marijuana Use in Hospitals

415 Distracted Driving Legislation

416 Non-Medical Exemptions from Immunizations

417 Improved Health in the United States Prison System Through Hygiene and Health Educational Programming for Inmates and Prison Staff

418 Eliminating the Death Toll from Combustible Cigarettes

419 Universal Access for Essential Public Health Services

420 Coordinating Correctional and Community Healthcare

421 Contraception for Incarcerated Women

422 Promoting Nutrition Education Among Healthcare Providers

423# Mandatory Immunizations for Asylum Seekers

424# Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

425# Distracted Driver Education and Advocacy

426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities

427# Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled

428# Dangers of Vaping

429# Support for Children of Incarcerated Parents

Contained in the Handbook Addendum

Reference Committee D

Resolution(s)

430# Compassionate Release for Incarcerated Patients

431# Eliminating Recommendations to Restrict Dietary Cholesterol and Fat

432# Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals

433# Transformation of Rural Community Public Health Systems

434# Change in Marijuana Classification to Allow Research

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-19

Subject:	Policy and Economic Support for Early Child Care (Resolution 416-A-17)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee D (Diana Ramos, MD, MPH, Chair)

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that our American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members. Board of Trustees Report 27 was submitted to the HOD at the 2018 Annual Meeting.

Reference Committee D received testimony that supported the general policy intent of the original resolution and also the recommendations in BOT Report 27-A-18. Testimony was also received pointing out that that smaller employers (including small practices) could face potential challenges in running their businesses if they were required to comply with new time off policies that may be more appropriate for larger employers as was pointed out in the original Board Report. There was further testimony and suggestions that the House go back to the original language in Resolution 416-A-17. The HOD referred BOT 27-A-18 back to the Board for additional study.

This report addresses the recommendations of Reference Committee D, and discusses the language in the original resolution, and any new developments in additional research. It also adopts by reference the analysis and recommendations of the original BOT Report 27-A-18 and provides additional recommendations.

The Background, policy discussion, research and legislative activities noted below are from the original BOT Report 27-A-18 and are considered still relevant to the issue today. New information in response to the testimony and referral from Reference Committee D is in italics in the discussion and recommendation porrtion of this Board Report.

BACKGROUND (From: BOT Report 27-A-18)

Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries.[1]

Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 (FMLA) in the US was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among

women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave.

Although the FMLA requires larger employers to provide unpaid job-protected time off, there is no current federal law that requires employers to provide paid time off for the birth or care of children. About 38 percent of employers offer paid parental leave for employees who are new parents.[2] Paid parental leave is distinct from other paid-leave programs such as short-term disability, sick days, and government-funded disability or insurance payments.[3] Smaller employers in particular are less likely to provide meaningful paid time off beyond generic vacation or sick time. Further, much of the time off that is provided as it relates to children is oriented toward the period surrounding the birth of a child and typically does not extend to infants and young children as contemplated by Resolution 416-A-17. What success there has been in providing paid parental leave has been primarily at the state and local level and with a small number of high profile employers. For example, IBM offers 20 weeks of paid maternity leave to both salaried and hourly workers who are birth mothers and offers 12 weeks of paid paternity leave for all other parents.[4] A few states have enacted paid medical and family leave laws – California, New Jersey, New York and Rhode Island. Additionally, a number of cities have enacted paid leave policies but most are oriented toward paid sick leave. While upwards of 20 other states have proposed their own paid leave laws, none have yet enacted a law. Regarding tax incentives to support early child care, tax law changes for 2018 raised child care tax credits up to a maximum of $2000 per child. The amount of the credit is indexed by income level. The credits do not differentiate between medically-related child care and general day care. This provision of the tax code already allows amounts paid to certain extended family members to be considered in the tax credit calculation under certain circumstances. For instance, if a child was sick at home and both parents had to work, a grandmother could provide care and if paid, the expense could be considered in the credit calculation, but the expenses are still subject to the maximums.

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave becomes necessary due to documented medical conditions (Policy H-420.979). The AMA recognizes the public health benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not specifically endorsed by the AMA. Council on Medical Service (CMS) Report 3-A-16 provided a comprehensive review of sick leave and paid leave policies. The HOD adopted the recommendations in the report, which established policy supporting employer policies that provide employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).

As it relates specifically to physician practices, AMA Policies for Parental, Family and Medical Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

Existing AMA policy also includes Policy H-405.954, "Parental Leave." BOT Report 9-I-17 was written and filed as an informational report, primarily to address possible expansion of the FMLA, but also made reference to paid parental leave. Policy H-405.954 states that the AMA will: "(1) encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction in the number of employees from 50 employees; (b) an increase in the number of covered weeks from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA expansion on physicians in varied practice environments."

RESEARCH AND LEGISLATIVE ACTIVITIES

Currently, federal law does not require employers to provide paid family or parental leave. The FMLA requires employers of a certain size to provide medically-related unpaid time off.

The most recent effort at the federal level to provide a broad paid parental leave approach is currently stalled. The Family and Medical Insurance Leave Act ("FAMILY Act," H.R. 947/S. 337) was introduced in Congress in 2017. The bill would, among other things, provide paid family and medical leave to individuals who meet certain criteria. It would be financed through a tax on every individual and employer, and all self-employment income. Thus far, the bill has been supported by Democratic members of Congress and has seen little action since introduction. The bill as originally drafted would:

- Create a national program to provide all workers, regardless of company size, with up to 12 weeks of partially paid leave; and
- Enable workers to receive up to 66 percent of their monthly wages, up to a capped amount, during their time of leave.

The AMA has not taken a position on this bill. In 2016 the Society for Human Resources Management (SHRM) partnered with the Families and Work Institute to conduct a National Study of Employers (NSE) practices on workplace benefits, and paid parental leave was part of that study.[5] The study seems to be the most recent and relevant broad-based employer analysis of what policies are in place today for parental leave as well as trends for the future.

The NSE's surveys have been conducted five times since 2005, providing both snapshots in time and current trends in employer practices and attitudes. The 2016 study samples 920 employers with more than 50 employees, with a blend of for-profit and non-profit as well as single and multi-cite locations. Note that the findings cited below all relate to employers with more than 50 employees.

The NSE noted that despite announcements of expanded parental leave benefits from Netflix, Amazon, Microsoft, Johnson & Johnson, Ernst & Young and a few others, "The media blitz over the past few years regarding paid parental leave was not representative of the majority of U.S. employers with 50 or more employees in 2016."[5] It also noted that the average maximum number of weeks of parental and caregiving leaves did not change significantly between 2012 and 2016, and in fact the average number of weeks provided had slightly declined when looking back to pre-recession 2005. 2016 data showed that employers seemed to be more supportive of easing the transition of a parent back into the workforce upon the birth of child (81% of employers), and more supportive of work from home options (40 percent of employers), but the percentage of employers allowing at least some employees to take time off during the workday for family or personal needs without loss of pay had declined from 87 percent to 81 percent.

Another finding demonstrated that employer support for flexible work arrangements had dropped dramatically from 31 percent in 2005 to 14 percent in 2016. While definitive research was not available to explain this change, it may be that many employers had narrowed benefit offerings during the prolonged period of economic difficulty that began in 2008. While the study tended to focus more on whether employers provided time off, it did note that of those employers providing at least some pay to women during maternity leave, most (78 percent) did so by providing some type of short term disability pay. The survey also indicated that for those employers that do offer pay, 6 percent of employers offered full pay, 39 percent offered partial pay, and 11 percent said it depends on the situation. Forty-two percent of the employers responding offered no pay at all. However, in contrast to those findings, the same report indicated that 39 percent of employers

allowed employees to take time off (at least 5 days) to care for *mildly ill* children without having to use vacation days or losing pay. The implication of this particular data is that employer policies on paid time off lack consistency.

As articulated in Board of Trustees Report 9-I-17, there is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16.[6] Paid sick leave has been increasing throughout the United States whether by state or local law mandates or decisions by employers. However, paid leave to care for others outside of paid vacation, PTO (generic paid time off), or paid sick leave is still not prevalent in the US.

Given that only a handful of states have enacted paid parental leave programs, research on their effectiveness is limited. However, what little research there is has demonstrated generally neutral to positive feedback from employers. In particular, BOT Report 9-I-17 noted California's experience:

> In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial burden as a result of the law, they are faced with ensuring the employees' workload is covered and that gaps in staffing are filled. The program in California, however, does not assure job protection during leave, provides wage replacement at only 55 percent, and does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-year review of California's expansion demonstrated that the Paid Family Leave benefit promoted family well-being, improved family economic security, equalized access to leave across occupations and income levels, and bolstered businesses by reducing workforce turnover. It was also noted that overall awareness of the program among those most likely to utilize it was low, implying that utilization rates could be higher if education and outreach were improved upon. Similar outcomes have been reported for other cities and states.[7-9]

An analysis published by IMPAQ International, Inc. and the Institute for Women's Policy Research summarizes a simulation of five paid family and medical leave model programs based on working programs in three states and a federal proposal, all applied to the national workforce. The findings suggest that expansion of FMLA laws, through covering more eligible workers, replacing a larger percentage of usual earnings, and offering more weeks of paid leave would increase costs. If based on any of the five models in the simulation, the cost for benefits would range from $31 billion to $43 billion. This report also projects that a national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually.[10]

Some employer groups claim paid leave policies or policies that provide coverage for more employees may burden and negatively impact employer operations.

When predicting employer reactions to programs, policies and benefits related to caregiving leaves and child and elder care, the NSE research articulated four primary factors: (1) the demographics of their workplace; (2) the demographics of the workforce; (3) financial health of the employer; and (4) human resources issues such as the difficulty or ease of attracting and retaining employees as well as the costs of employee benefits.

The attitude and approach of employers is fundamental to progress on a broad national approach to paid parental leave. It is not atypical for employers to consider all four of these factors when

considering what benefits to offer their employees. As it relates to paid time off, some employers are specific about how that time can be used (vacation, sick time). Other employers are more flexible ("paid time off"), wherein the employer provides a bank of paid time off that employees can use for any purpose. Employers typically review benefits offerings every year, with time off being only one of a myriad of benefits being evaluated.

As noted above, recent changes in the federal tax code increased the child care tax credit up to $2000 per child. While it may be debatable whether the increase goes far enough, it is a positive step forward toward the intent of Resolution 416 and supporting the child care efforts of people with lower economic status.

While there has been recent publicity about proposals to have some type of child care financial assistance by allowing people to draw down future Social Security benefits, it does not seem at present that such proposals will receive meaningful consideration in Congress.

DISCUSSION

The Board's review of existing research has demonstrated that despite positive health outcomes for children being cared for by their parents, meaningful progress on national policy mandating paid parental leave is unlikely in the near term. The necessary broad-based support of employers to support such policy is simply not present at this point in time. Additionally, the anti-regulatory views of the current Administration and political climate in Washington DC may not be ripe for federal policy or action on paid family leave.

The first resolve of Resolution 416-A-17 asked the AMA to advocate for improved social and economic support for paid family leave to care for newborns, infants and young children. The Board of Trustees believes that there would be considerable challenges to pursuing a public policy that would require employers to provide paid parental leave. Nevertheless, the Board believes that HOD policy supporting paid parental leave for the care of children is good public policy. Policy H-440.823 does support employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. As noted earlier in this report, approximately 38 percent of employers currently offer paid parental leave for employees who are new parents. Accordingly, the Board of Trustees also supports encouraging employers to offer and/or to expand these types of policies. The Board believes that state medical associations should also be encouraged to work with their state legislatures to establish and promote parental leave policies.

The second resolve of Resolution 416-A-17 asked the AMA to advocate for federal tax incentives to support early child care and unpaid child care by extended family members. As previously noted in this report, recent changes to Federal tax law have raised child care tax credits to a maximum of $2000 per child, beginning in 2018. The expense of paying extended family members to perform child care can be considered in the calculation of this credit under certain circumstances.

As noted in prior Board reports on paid parental leave proposals, there are several primary sources that influence progress. The first is the general proposition that such policies are, in and of themselves, the right thing to do for the betterment of public health as noted in the original Resolution 416-A-17. The second and third would be governmental action at the state or federal level either requiring or encouraging via incentives compliance with potentially new law or regulations. The fourth is action by employers in making decisions on benefit offerings to their employees.

It should be noted that there is little new additional research available to inform these issues beyond that articulated in Board Report 27-A-18. However, at the federal level several new bills have been introduced new Congress. The FAMILY Act, originally introduced in both the House and Senate in 2017 has been reintroduced, but as of yet has support only from Democrats. HR 1185 has been introduced in the House with 178 Democratic co-sponsors. S 463 has been introduced in the Senate with 34 Democratic cosponsors. No hearings have yet been scheduled on any of the bills and none of them yet seem to have traction with Republicans.

Given that testimony at Reference Committee D suggested the possibility of going back to the original language of Resolution 416 A-17, and the fact that there are competing proposals in Congress the Board believes it prudent to support the original resolutions but also restate portions of the Board's recommendations from BOT Report 27-A-18 and continue to study and monitor developments as more specifics be available.

RECOMMENDATIONS

Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 416-A-17 and the remainder of this report be filed.

1. That our AMA reaffirm Policy H-440.823, which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. (Reaffirm HOD Policy)

2. That our AMA encourage employers to offer and/or expand paid parental leave policies. (New HOD Policy)

3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies. (New HOD Policy).

4. *That our AMA advocate for improved social and economic support for paid family leave to care for newborns, infants and young children (New HOD Policy).*

5. *That our AMA advocate for federal tax incentives to support early child care and unpaid child care by extended family members (New HOD Policy).*

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-19

Subject:	Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients (Resolution 826-I-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee D (Diana Ramos, MD, MPH, Chair)

At the 2018 Interim Meeting, the House of Delegates referred Resolution 826, Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients, which was introduced by the Resident and Fellow Section. Resolution 826 asked that our AMA "work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals." The resolution further asked that our AMA reaffirm Policy H-270.962, Unfunded Mandates, and Policy H-130.940, Emergency Department Boarding and Crowding.

This report (1) explores how homelessness contributes to emergency department (ED) overuse and hospitalization, (2) outlines current regulatory requirements related to homelessness and discharge planning, and (3) describes the need for broader efforts to address the unique healthcare and social needs of homeless patients.

BACKGROUND

Homeless individuals are more likely than the general population to experience behavioral health disorders, acute and chronic conditions, and injuries resulting from assaults and accidents. This increased prevalence, in concert with lack of insurance or access to a usual source of medical care, leads homeless individuals to seek care at EDs at a high rate and increases their rates of hospitalization. Indeed, as many as two-thirds of homeless individuals visit an ED each year, as compared to just one-fifth of the general population, and the hospitalization rate for homeless individuals is as much as four times higher than that for non-homeless individuals.[1-6]

Not only are homeless patients more likely to visit an ED, but they are also more likely to re-visit an ED. Indeed, an analysis of national ED utilization rates found that homeless patients were more than three times as likely as non-homeless patients to have been evaluated in the same ED within the previous three days, and were more than twice as likely to visit an ED within a week of discharge from the hospital.[7]

ED utilization is not uniform across the homeless population, with one study representative of the literature on the topic finding that a small proportion of frequent users (7.9%) account for an outsized proportion of total use (54.5%).[5] Anecdotal accounts, which are not uncommon, cite cases of individual homeless patients with more than 100 ED visits in a year and total costs topping $1 million.[8,9]

DISCUSSION

Discharge planning and ED overuse

As suggested by Resolution 826-I-18, hospital and ED discharge planning plays a key role in ending the revolving door of ED visits, hospitalizations, and readmissions, especially among homeless frequent users. Specifically, evidence shows that well-coordinated case management (the development and initiation of which is a key outcome of discharge planning) may reduce ED use and costs, and improve both clinical and social outcomes for homeless patients.[10-12] Despite these findings, discharge planning for homeless patients remains rare: one analysis found that 64% of ED visits resulted in homeless patients being discharged back to the street, with only 4% having a discharge plan addressing their housing status.[13]

Current approaches to discharge planning also overlook important opportunities to improve the health of homeless patients in areas unrelated to their ED visits. For example, given that the CDC Advisory Committee on Immunization Practices now recognizes "homelessness" as an indication for hepatitis A vaccination,[14] patient encounters in the ED present an excellent opportunity to assess immunization status and need for vaccination, and to administer vaccines or refer patients for vaccination.[15] As an added bonus, this holistic approach ensures that homeless patients are immunized, which helps keep them well and out of the ED.

Hospital requirements for discharge planning

Recognizing the value of discharge planning in preventing hospital readmissions, the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) include comprehensive discharge planning requirements for hospitals participating in the Medicare or Medicaid programs. These requirements include:

(1) Identifying inpatients for whom discharge planning is necessary;[*]

(2) Providing a discharge plan evaluation to each identified patient, which "must include an evaluation of the likelihood of a patient's capacity for selfcare or of the possibility of the patient being cared for in the environment from which he or she entered the hospital;"

(3) Developing and "[arranging] for the initial implementation of the patient's discharge plan;"

(4) Transferring or referring the patient, "along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care;" and

(5) Reassessing the discharge planning process "on an on-going basis;" which must include "a review of discharge plans to ensure that they are responsive to discharge needs."[16]

The CoPs do not require discharge planning for ED visits without hospital admission, which are categorized as outpatient visits. However, in recent revisions to its interpretive guidelines for discharge planning, CMS observes that "many of the same concerns for effective posthospital care coordination arise [for outpatients] as for inpatients" and therefore recommends that "hospitals

[*] Note that "in the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan…[and] the hospital must develop a discharge plan for the patient."

might consider utilizing, on a voluntary basis, an abbreviated post-hospital planning process for certain categories of outpatients...and for certain categories of emergency department discharges."[17]

At the state level, in 2018 California adopted regulations requiring more stringent discharge planning requirements and services for homeless patients. Set to take effect July 1, 2019, these new regulations require California hospitals to "include a written homeless patient discharge planning policy and process within the hospital discharge policy."[18] The law further requires hospitals to perform a variety of specific tasks and in a specific manner, including but not limited to:

- logging all discharges of homeless patients;
- providing a meal, clothing, medication, and transportation upon discharge;
- coordinating with social service agencies; and
- discharging homeless patients only during the daytime.[19,20]

The California law was met with concern by many in the healthcare community, including the California chapter of the American College of Emergency Physicians and the California Hospital Association.[20,21] While recognizing the importance of and supporting appropriate discharge planning and protocols, critics questioned the feasibility of many aspects of the law—for example, how exactly would a hospital go about maintaining a supply of clothing for homeless patients? They also pointed to severe unintended consequences of the law—for example, that prohibiting overnight discharges would further exacerbate ED overcrowding and constrain hospitals' capacity to provide timely, lifesaving care to those patients who need it most. And, at the broadest level, they questioned why the societal costs of homelessness should be borne by hospitals, especially safety net hospitals that treat a disproportionately large share of homeless patients and are least able to comply with unfunded mandates.

Moving beyond discharge planning

Effective ED and hospital discharge planning constitutes just one component of what ought to be a more comprehensive approach to addressing the unique healthcare needs of homeless patients—one which, as stated by CMS in its interpretive guidelines for discharge planning, "moves away from a focus primarily on a patient's hospital stay to consideration of transitions among the multiple types of patient care settings that may be involved at various points in the treatment of a given patient."[17]

Central to these more comprehensive efforts is housing security, an area in which, in the absence of comprehensive state and local homelessness strategies, hospitals and health systems have been obligated to take action in recent years. In 2017, for example, the American Hospital Association published a guidebook, *Housing and the Role of Hospitals*, identifying how hospitals can address this particular social determinant of health. This resource outlines strategies and provides case studies on:

- neighborhood revitalization;
- home assessment and repair programs;
- medical care for the homeless;
- medical respite care; and
- transitional or permanent supportive housing.[22]

The last of these strategies has received considerable attention, with hospitals and health systems investing an estimated $75 to $100 million in housing for homeless patients.[23] Insurers and local units of government also have contributed to these efforts, typically in partnership with hospitals

and health systems.[24-26] Initial outcomes data on these endeavors suggest that providing housing for homeless patients can decrease ED use and hospitalizations while yielding net savings on combined expenditures for healthcare and social services.[27] Despite these outcomes, the long-term desirability and feasibility of this approach is uncertain, as questions of appropriate resource allocation (is there a better way to spend these monies?), cost-sharing (is it appropriate to ask hospitals to cover the cost of social services for homeless patients?), and society's overall approach to eliminating homelessness remain unresolved.

AMA policy on discharge planning and care for homeless patients

AMA policy recognizes the link between housing security and health outcomes, and supports a coordinated, collaborative approach to care for homeless patients that combines clinical and social services. For example, Policy H-160.903, Eradicating Homelessness, "supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services."

Furthermore, Policy H-160.978, The Mentally Ill Homeless, avers that "public policy initiatives directed to the homeless, including the homeless mentally ill population, should…[promote] care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities."

Finally, the AMA's comprehensive Evidence-Based Principles of Discharge and Discharge Criteria (Policy H-160.942), while not explicitly addressing homelessness, "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."

CONCLUSION

Homelessness is an exacerbating factor in ED overuse, excess hospitalization, and preventable readmissions. Hospital discharge planning for homeless patients, with a holistic focus on case management that coordinates clinical and social services, has been shown to alleviate some of these problems. Despite this evidence, focused discharge planning remains rare for homeless ED patients. Our AMA should educate physicians about the importance of discharge planning for homeless patients, and encourage the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.

While critical, discharge planning alone will not prevent unnecessary ED visits and hospitalizations for homeless individuals. Instead, a more comprehensive approach to addressing the unique healthcare and social needs of homeless patients is required, with efforts reaching beyond the hospital and into the community. Our AMA should encourage collaborative efforts to address homelessness that do not leave hospitals and physicians alone to bear their costs.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 826-I-18 and that the remainder of the report be filed:

1. That our American Medical Association partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs. (Directive to Take Action)

2. That our AMA encourage the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital. (New HOD Policy)

3. That our AMA encourage the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients. (New HOD Policy)

4. That our AMA reaffirm Policy H-160.903, Eradicating Homelessness, which "supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services." (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that "public policy initiatives directed to the homeless, including the homeless mentally ill population, should…[promote] care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities." (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and Discharge Criteria, which "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." (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-130.940, Emergency Department Boarding and Crowding, which "supports dissemination of best practices in reducing emergency department boarding and crowding." (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes any unfunded mandates on physicians." (Reaffirm HOD Policy)

Fiscal Note: $5,000

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AMA POLICIES RECOMMENDED FOR REAFFIRMATION

H-160.942 Evidence-Based Principles of Discharge and Discharge Criteria

(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.

H-160.978 The Mentally Ill Homeless

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

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

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

H-160.903 Eradicating Homelessness

Our American Medical Association:

(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;

(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and

(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-19

Subject:	Opposition to Measures that Criminalize Homelessness (Resolution 410-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee D (Diana Ramos, MD, MPH, Chair)

INTRODUCTION

Resolution 410-A-18, "Opposition to Measures that Criminalize Homelessness," introduced by the Medical Student Section and referred by the House of Delegates asks that:

> Our American Medical Association oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces; and advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights.

CURRENT AMA POLICY

Existing AMA policy supports improving health outcomes and decreasing the health care costs of treating people who are chronically homeless through clinically proven, high quality, and cost-effective approaches, which recognize the positive impact of stable and affordable housing coupled with social services. The AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless. Furthermore, the AMA recognizes that lack of identification is a barrier to accessing medical care and fundamental services that support health; and supports policy changes that streamline, simplify, and reduce or eliminate the cost of obtaining identification cards for the homeless population. Current policy does not specifically address criminalizing homelessness.

BACKGROUND

Insufficient income and lack of affordable housing are leading causes of homelessness in the United States. The Great Recession contributed to a shortage of affordable housing. It is estimated that we currently have a shortage of 7.2 million rental homes affordable and available to extremely low-income renters (those whose income is at or below the poverty guideline or 30 percent of their area median income).[1] Extremely low-income households face a shortage of affordable housing in every state and major metropolitan area. In addition to the shortage of affordable housing, in many U.S. cities, there are fewer shelter beds than are needed, leaving people experiencing homelessness with no choice, but to live in public places.[2]

In January 2018, almost 553,000 people were homeless on a single night in the United States, with nearly two-thirds found in emergency shelters or transitional housing programs.[3] While the number

of people experiencing homelessness increased by less than one percent between 2017 and 2018, overall homelessness has declined by more than 84,000 people (13 percent) since 2010.[4] In the United States, sixty percent of people experiencing homelessness in 2018 were men or boys, and 39 percent were women or girls.[5] Less than one percent were transgender or gender nonconforming.[6] Nearly half (49 percent) of all people experiencing homelessness self-identified as white and almost 40 percent identified as black or African American.[7] People identifying as white were underrepresented compared to their share of the U.S. population (72 percent), while African Americans were considerably overrepresented compared to their share of the U.S. population (13 percent).[8] One in five people experiencing homelessness was Hispanic or Latino (22 percent), which is slightly higher than their share of the U.S. population (18 percent).[9]

Substance use disorders and mental health problems are more prevalent among people who are homeless than in the general population. According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition.[10] Lack of stable housing leaves them vulnerable to substance use and/or relapse, exacerbation of mental health problems, and a return to homelessness.[11]

Laws Criminalizing Homelessness

Criminalizing homelessness refers to laws enacted by municipalities to prohibit life-sustaining activities such as sitting, sleeping, loitering, panhandling, camping, eating, storing belongings, and urinating in public spaces. Laws criminalizing homelessness trap vulnerable populations in the criminal justice system.[12] The continuous threat of citations and possibility of arrest contributes to a pervasive sense of fear and insecurity among the homeless population. For individuals experiencing homelessness, fines typically cannot be paid, leaving individuals to contest citations in court.[13] Without a reliable address or transportation, citations can result in not receiving a notice to appear in court or having no way to get there. Failure to appear in court can result in a warrant for arrest.[14] Arrests and criminal records make housing, employment, and social services more difficult to access thereby perpetuating the cycle of homelessness and health inequity.[15]

Laws criminalizing homelessness have increased in cities across the United States over the past 10 years.[16] Since 2006, citywide bans on loitering, loafing, and vagrancy increased by 88 percent, bans on camping increased by 69 percent, bans on sitting and lying down in certain public places increased by 52 percent, bans on panhandling grew by 43 percent, and bans on sleeping in public increased by 31 percent.[17] These laws are designed to move visibly homeless people out of commercial and tourist districts and are often justified based on the government's responsibility to maintain orderly, aesthetically pleasing public parks and streets as well as the responsibility to protect public health and safety.

DISCUSSION

Laws criminalizing homelessness have been found to violate international and, in some instances, federal law. In 2014, the United Nation's (UN) Committee on the Elimination of Racial Discrimination, called on the United States to abolish laws and policies making homelessness a crime and ensure cooperation among stakeholders to find solutions for people experiencing homelessness in accordance with human rights standards.[18] Furthermore, the UN encouraged the United States to provide incentives to decriminalize homelessness, including financial support to local authorities that implement alternatives to criminalization, and withdrawing funding from local authorities that criminalize homelessness.[19]

In 2017, the UN Special Rapporteur on extreme poverty and human rights visited the United States to report to the Human Rights Council on the extent to which the government's policies and programs relating to extreme poverty are consistent with its human rights obligations and to offer recommendations to the government and other stakeholders. The report stated that:

> In many cities, homeless persons are effectively criminalized for the situation in which they find themselves. Sleeping rough[1], sitting in public places, panhandling, public urination and myriad other offences have been devised to attack the 'blight' of homelessness… Ever more demanding and intrusive regulations lead1 to infraction notices for the homeless, which rapidly turn into misdemeanours, leading to warrants, incarceration, unpayable fines and the stigma of a criminal conviction that in turn virtually prevents subsequent employment and access to most housing. [20]

Courts in the United States have come to differing conclusions on laws criminalizing homelessness, particularly anti-camping ordinances, due to differing interpretations of whether the Eighth Amendment's protection against cruel and unusual punishment prohibits only criminalization of status or also the criminalization of involuntary conduct.[21] In 2015, the United States government issued a statement indicating its position on the issue in the case of *Bell et al v. City of Boise*:

> If the Court finds that it is impossible for homeless individuals to secure shelter space on some nights because no beds are available, no shelter meets their disability needs, or they have exceeded the maximum stay limitations, then the Court should also find that enforcement of the ordinances under those circumstances criminalizes the status of being homeless and violates the Eighth Amendment to the Constitution.[22]

In the case in question, the 9th Circuit Court of Appeals held that the Cruel and Unusual Punishments Clause of the Eighth Amendment precluded enforcement of a statute prohibiting sleeping outside against homeless individuals with no access to alternative shelter. The court held that as long as there is no option of sleeping indoors, the government cannot criminalize indigent, homeless people for sleeping outdoors, on public property, on the false premise that they had no choice in the matter.[23] The court further explained that "[e]ven where shelter is unavailable, an ordinance prohibiting sitting, lying, or sleeping outside at particular times or in particular locations might well be constitutionally permissible. So, too, might an ordinance barring the obstruction of public rights of way or the erection of certain structures."[24]

Homeless Bill of Rights

Rhode Island, Illinois, and Connecticut, and Puerto Rico have enacted laws that protect the civil rights of people experiencing homelessness, these laws are referred to as a Homeless Bill of Rights. While the laws vary by jurisdiction, they specify that a person who is homeless has the same rights and privileges as any other state resident. The laws each outline the rights of persons experiencing homelessness (i.e. move freely in public spaces, receive equal treatment by state and municipal authorities, not face discrimination while seeking or maintaining employment, access to emergency medical services, etc.).[25] The impact these laws have had is unclear.

[1] Sleeping rough" – refers to sleeping outside without shelter

Public Health Nuisance Laws

Actions by government officials aimed at individuals experiencing homelessness are often justified based on public health and safety concerns. While laws criminalizing homelessness are of concern, it should be clear that there are legitimate instances in addressing homeless populations where the government needs to act to protect the health of the public. For example, the environmental conditions associated with homelessness, which can include overcrowding in encampments and shelters, exposure to the elements, and poor hygiene, facilitate the transmission of infectious diseases.

The United States is currently experiencing the worst multi-state outbreak of hepatitis A virus (HAV) in over 20 years, due in part to the lack of access to proper sanitation and hygiene among persons experiencing homelessness.[26] In response to this multi-state HAV outbreak, the CDC's Advisory Committee on Immunization Practices, voted in 2018 to add a new policy recommending that everyone ages 1 and older who is experiencing homelessness routinely be immunized against hepatitis.[27] In some jurisdictions, there have been campaigns to vaccinate and educate people at risk and to provide portable hygiene facilities in areas where people who are homeless congregate. To address public health risks, some jurisdictions have created sanctioned tent encampments where they provide essential public services to help ensure that residents are in a safe environment. It has been cautioned that while these measures may prevent immediate harm, they are not long-term solutions to the problem of homelessness in the United Sates. [28]

CONCLUSION

Insufficient income and lack of affordable housing are leading causes of homelessness in the United States. Laws criminalizing homelessness, or laws prohibiting life-sustaining activities in public spaces when there are no sheltered alternatives, have increased in U.S. cities over the past 10 years. These laws trap vulnerable populations in the criminal justice system and raise both human rights and constitutional concerns. Actions by government officials aimed at individuals experiencing homelessness are often justified based on public health and safety concerns. While there are instances where the government needs to act to protect public health and safety, such as during an infectious disease outbreak, governments should work to mitigate hazards and direct individuals to resources and services outside of the criminal justice system. Criminal sanctions should be a last resort.

Current AMA policy recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless. In addition, to reaffirming this policy, the AMA should recognize the lack of affordable housing as a leading cause of homelessness and support measures to address this problem through policies that preserve and expand affordable housing across all neighborhoods.

RECOMMENDATIONS

The Board of Trustees recommends that the following statements be adopted in lieu of Resolution 410-A-18 and the remainder of the report be filed.

1. That our American Medical Association: (1) supports laws protecting the civil and human rights of individuals experiencing homelessness and (2) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e.,

eating, sitting, or sleeping) when there is no alternative private space available. (New HOD Policy)

2. That our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. (New HOD Policy)

3. That our AMA reaffirm Policy H-160.903, "Eradicating Homelessness"
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness; and (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (Reaffirm Current HOD Policy)

Fiscal Note: less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 29-A-19

Subject:	Improving Safety and Health Code Compliance in School Facilities (Resolution 413-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee D (Diana Ramos, MD, MPH, Chair)

INTRODUCTION

Resolution 423-A-18, "Improving Safety and Health Code Compliance in School Facilities," which was introduced by the Medical Student Section, and was referred by the House of Delegates, asked:

> That our American Medical Association (1) support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections; and (2) That our AMA support policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods; and (3) That our AMA support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure.

Testimony during reference committee noted that there are already extensive guidelines provided for schools by the Centers for Disease Control and Prevention, Environmental Protection Agency, and state departments of health, and that our American Medical Association should review guidelines from these sources. It was further noted that there is no governing body that enforces the compliance of safety standards in schools. This report addresses school environmental health and safety.

CURRENT AMA POLICY

Existing American Medical Association (AMA) policy addresses environmental health and safety, including drinking water and indoor air quality (see Appendix for full text). Relevant to this report is AMA Policy H-135.928, "Safe Drinking Water," that supports creating and implementing standardized protocols and regulations pertaining to water quality testing, and reporting and remediation to ensure the safety of water in schools. AMA Policy H-135.998, "AMA Position on Air Pollution," also supports maximum feasible reduction of all forms of air pollution, including biologically and chemically active pollutants, by all responsible parties, as governmental control programs are implemented primarily by local, regional, or state jurisdictions which possess the resources to bring about equitable and effective control.

BACKGROUND

School Environmental Health and Safety

Children are a vulnerable population with smaller body size and higher metabolism, which may increase susceptibility to environmental contaminants.[1] Children may also be more likely to encounter contaminants, due to proximity to the ground, where they may ingest substances such as toxic dust by placing objects in their mouths, and where levels of airborne pollutants may also be higher. Regardless of route of administration, encounters with toxins such as heavy metals can lead to lifelong negative health and behavioral impacts,[2] including via altered brain development.[3]

Safety implies prevention of unintentional injuries, a leading cause of death and disability among children. Unsafe environments can lead to chronic health conditions, including asthma and allergies. As many as 25 percent of school-age children in the United States have a chronic health condition. Children spend large amounts of time in schools, where better management of their chronic health conditions may be associated with improved academic achievement.[4]

Budget shortfalls for school infrastructure impact school operating resources, negatively affecting routine and preventative maintenance, particularly in lower-income districts. Lack of well-maintained school environments can pose obstacles to student learning and well-being, negatively affect surrounding communities, and contribute to health inequities.[5]

Environmental health and safety laws and guidelines have been designed to protect private and public employees, students, the public, and the environment.[6] A complex jurisdictional arrangement throughout federal, state, county, and municipal levels may create confusion for schools about which regulations apply. The following provides a broad overview of various agencies and entities with interests in school environmental health and safety.

FEDERAL AGENCIES

The federal government's role in education has traditionally been limited, due to the Tenth Amendment of the U.S. Constitution, which reserves powers not assigned to the federal government for the states of the people. Rather than mandating direct federal oversight of schools, state and local districts have generally retained school regulatory authorities under existing law.

U.S. Environmental Protection Agency (EPA)

The EPA is responsible for protecting the environment and public through legislative mandates. These laws include air pollution, drinking water, pesticides, hazardous waste, and asbestos, among other topics. The Energy Independence and Security Act of 2007 added a requirement for the EPA to develop voluntary guidelines (together with other relevant federal agencies) for K-12 schools, and then assist states in establishing and implementing environmental health programs.[7]

Other recent EPA mandates address drinking water and aging infrastructure, including: the Drinking Water State Revolving Fund of 2013 that provides loans that support lead pipe replacement projects across the United States; the Water Infrastructure Improvements for the Nation Act of 2016 that supports grant programs[8] (e.g., the State Lead Testing in School and Child Care Program Drinking Water Grant[9]); the Water Infrastructure Finance and Innovation Act of 2018 that leverages funding for water infrastructure projects to reduce exposure to lead and other contaminants; and the America's Water Infrastructure Act of 2018 that offers programs and resources to help reduce lead in drinking water.

The EPA assists states and local school districts by providing grant support[10] and capacity building, developing policy and data tools,[11] and offering guidance on compliance and monitoring. The EPA's voluntary guidelines provide examples of best practices from existing state environmental health programs for schools, recommend a six-step plan states can use to build or enhance a sustainable school environmental health program, and provide extensive resources for states to promote healthy learning environments for children and school staff.

In addition to the voluntary guidelines, in 2018 the EPA announced the Tools for Schools program to support schools in ensuring clean, healthy, and environmentally conscious school communities. The Tools for Schools approach provides strategies and a robust suite of tools to help schools identify, correct, and prevent a wide range of environmental health and safety risks, and to put in place a sustainable system to institutionalize a successful program at the school or school district level.[13] The EPA also offers comprehensive Healthy Schools, Healthy Kids educational resources and tools to help maintain and enhance environmental health programs.[12] These resources include educating students and school staff about prevention and management, as well as hands-on resources such as inspection manuals for staff and pest management professionals.[14]

Centers for Disease Control and Prevention (CDC)

The CDC conducts critical science and provides health information that protects our nation against dangerous health threats, and responds when these arise. The CDC serves a key role in environmental health, as well as health promotion and education activities designed to improve health.

Various CDC centers and agencies address environmental health and safety, including the Agency for Toxic Substances and Disease Registry, which works towards minimizing risks associated with exposure to hazardous substances, and maintains toxicological profiles for substances; the Division of Adolescent and School Health, which collects data to monitor healthy and safe school environments such as School Health Policies and Practices Study[15] and conducts surveys of schools including School Health Profiles[16] covering asthma and other chronic conditions; and the National Center for Environmental Health which conducts research including the Environmental Public Health Tracking Program[17] and collects state surveillance data[18] on children affected by lead.

The National Institute for Occupational Safety and Health (NIOSH) has a Safety Checklist for Schools[19] to help K-12 schools with health compliance, including with EPA regulations and Occupational Safety and Health Administration (OSHA) standards. NIOSH also responds to requests to investigate health and safety problems in the workplace, via the Division of Surveillance, Hazard Evaluations, and Field Studies, including in public schools[20]. It also provides training in occupational safety and health, conducts occupational disease and injury research, and recommends standards to OSHA.

The School Health Index[21] was developed by the CDC as a confidential online self-assessment and planning tool that schools can use to help improve health and safety policies and programs. The CDC also has additional resources for drinking water access[22] through Healthy Schools,[23] which offers the Whole School, Whole Community, Whole Child (WSCC) model as a framework for addressing health in schools.[24] According to the WSCC model:

> The physical school environment encompasses the school building and its contents, the land on which the school is located, and the area surrounding it. A healthy school environment will address a school's physical condition during normal operation as well as during renovation

(e.g., ventilation, moisture, temperature, noise, and natural and artificial lighting), and protect occupants from physical threats (e.g., crime, violence, traffic, and injuries) and biological and chemical agents in the air, water, or soil as well as those purposefully brought into the school (e.g., pollution, mold, hazardous materials, pesticides, and cleaning agents).

A recent report[25] provided a comprehensive analysis of state policies for alignment with the CDC's WSCC model, and these findings are available by state and category,[26] including physical environment.

STATE AGENCIES

State agencies also play a role in school environmental health and safety, and these vary by jurisdiction. Those that may be relevant include the state departments of education, labor, environmental protection, community affairs, and health.[19]

Departments of Education

State departments of education issue regulations that deal with private and public schools, as well as regulations related to school construction. Besides regulations for environmental safety and health regulations, a state department of education or school district may also provide policies and/or guidelines related to environmental safety and health programs.

Departments of Labor

Although students are not generally covered by federal OSHA, state legislative mandates may "adopt by reference" the OSHA standards. "Adoption by reference" requires compliance in the state with federal OSHA requirements. State OSHA programs then assume responsibility for enforcing regulations through the state department of labor, including health and safety.

Departments of Environmental Protection

In most states, the state EPA covers the same areas addressed by federal EPA, such as air pollution, drinking water, hazardous waste, pesticides, and noise pollution. When incorporated into state regulations, state EPAs are authorized by the U.S. EPA to enforce almost all EPA regulations. States have typically assumed responsibility for enforcement of EPA mandates, following adoption of their own state regulations, including inspections and enforcing EPA regulations in schools. The U.S. EPA provides voluntary guidelines for states to follow, and encourages a leadership role from state agencies, such as more comprehensive strategies, including by using available resources such as model programs for indoor air quality.[27]

Departments of Community Affairs

Agencies such as the Department of Community Affairs may enforce state fire safety and building regulations. In many states, cities and counties are free to adopt their own codes, in the absence of state codes.

Departments of Health

State departments of health enforce health regulations directed by legislative mandate. Health departments may also work with schools and local health departments to provide technical assistance on school environmental health and safety issues and promote best practices.

LOCAL GOVERNMENTS

Various codes and standards have been adopted by states, counties, cities/towns and districts to help ensure school safety. One example includes building codes, which may also regulate children's play spaces and equipment. Another example is fire protection codes that address topics such as means of egress from buildings. Many safety codes apply to public schools via entities such as the local building or fire department,[28] and some cover environmental health areas such as radon testing and elimination. At state or city levels, additional public safety statutes may apply.[29]

KEY AREAS OF SCHOOL ENVIRONMENTAL HEALTH AND SAFETY

Air Quality

Airborne contaminants including mold[30] and chemicals such as cleaning products and pesticides, can trigger a variety of health issues, including allergies and asthma. Various state indoor air quality statutes cover topics such as HVAC system inspection and inadequate ventilation, while others focus primarily on green cleaning. Nearly every state has a statute that heavily regulates smoking in schools and most prohibit smoking in schools completely. There is no state statute that encompasses all facets of indoor air quality safety in schools.

Chemical Hazards

Asbestos. Asbestos minerals are a group of silicate compounds that cause chronic lung disease and have been classified as a known human carcinogen.[31] Asbestos statutes generally pertain to any public building and not just schools, and require certification and licensure before any contracting can occur for an asbestos abatement program, and substantial monitoring before and during any programs. Most state statutes provide for state or federal money for abatement programs in public buildings, including schools.

Radon. Radon is a colorless, odorless radioactive gas that seeps into buildings from surroundings, and can become trapped inside. Some states have radon statutes that provide that schools must be checked for radon, but most states delegate authority to various departments in the state.

Lead. Lead is a neurotoxin for which young children are particularly susceptible. Lead exposure is linked to impaired brain and nervous system development during childhood and associated with adverse effects including behavioral problems and additional health conditions later in life. Nearly every state has a statute that mitigates lead risks, though most are focused on reducing the risks of lead-based paint. Of the states that specifically address children, many only address children up to age six. The EPA offers voluntary guidance[13] for preventing and mitigating some lead hazards in schools, including drinking water.[32]

Water Quality

Currently, no federal law requires testing for lead in school drinking water. Although public water systems are regulated by the EPA, this regulation does not apply to downstream users such as schools. To date, federal agencies including the EPA, Department of Education and CDC have had a limited role in monitoring school drinking water. Improved federal guidance has been called for by the Government Accountability Office.[33]

In 2017, 41 percent of school districts nationwide had not tested their water for lead, and additional 16 percent reported that they did not know whether the water had been tested.[33] In 2016, New York became the first state to require lead testing in school drinking water and by 2018, 15 states had requirements for lead testing in school drinking water[34] but many jurisdictions do not have programs to test for lead in drinking water.

Recent findings have highlighted challenges due a lack of standardized practices in data collection, reporting, and decision making. When testing has been performed, elevated levels of lead have often been found, and many schools must decide the levels that trigger retesting, prevent continued use of the source, and eventually spur remediation efforts.

CONCLUSION

Children are a vulnerable population and are susceptible to environmental contaminants. Given the amount of time children spend in schools, promoting healthy school environments is of importance. Existing guidelines recommend steps towards sustainable school environmental health programs, and additional tools are available to help schools implement guidelines to promote children's health. While some state and local governments have adopted these guidelines into law, overall adoption and enforcement of such guidelines remains voluntary. Budgets and school operating expenses directly impact school building infrastructure and maintenance. Schools in lower-income districts may be particularly vulnerable to environmental health hazards, which can pose obstacles to student learning and well-being, and contribute to health inequities.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 413-A-18 and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

   "Environmental Health and Safety in Schools"
   Our AMA supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner. (New HOD Policy)

2. That the following policies be reaffirmed: H-135.928, "Safe Drinking Water," and H-135.998, "AMA Position on Air Pollution." (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

APPENDIX – Current AMA Policy

H-135.928, "Safe Drinking Water"
Our AMA supports updates to the U.S. Environmental Protection Agency's Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by: (1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems; (5) Creating and implementing standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers; (6) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (7) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (8) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; (9) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act; and (10) Actively pursuing changes to the federal lead and copper rules consistent with this policy.

H-135.998, "AMA Position on Air Pollution"
Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-19

Subject:	Low Nicotine Product Standard (Resolution 431-A-18)
Presented by:	Robyn F. Chatman, MD, MPH, Chair
Referred to:	Reference Committee D (Diana Ramos, MD, MPH, Chair)

Resolution 431-A-18, introduced by the American Thoracic Society and referred by the House of Delegates asks:

> That our American Medical Association (AMA) direct the Council on Science and Public Health to develop a report on the individual health and public health implications of a low nicotine standard for cigarettes. Such a report should consider and make recommendations on scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies to ensure compliance with an established standard, how a low nicotine standard should work with other nicotine products in a well-regulated nicotine market.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2018 to January 2019 using the search terms "nicotine standard," "nicotine content," and "very low nicotine content cigarette."

BACKGROUND

At the 2018 Annual Meeting of the House of Delegates, the Council on Science and Public Health (CSAPH) presented a report on "Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking." That report outlined the Food and Drug Administration's (FDA) plan to reduce the devastating toll of tobacco use and noted that the plan involves two primary parts: (1) reducing the addictiveness of combustible cigarettes and (2) recognizing and clarifying the role that potentially less harmful tobacco products could play in improving public health. The FDA also has acknowledged the need for medicinal nicotine and other therapeutic products to play a greater role in helping smokers to quit and remain nonsmokers.

On July 16, 2018, the AMA along with 39 other medical and public health organizations submitted comments to the Food and Drug Administration (FDA) on Docket No. FDA-2017-N-6189, Tobacco Product Standard for Nicotine Level of Combusted Cigarettes (See Appendix).[1] These comprehensive comments on the FDA's Advance Notice of Proposed Rule Making (ANPRM) addressed the following issues:

I. Public Health Impact of Reducing Nicotine in Combustible Tobacco Products
- A. Reducing the Nicotine Content of Cigarettes Will Help Smokers Quit
- B. Reducing the Nicotine Content of Combustibles Will Prevent Kids from Becoming Addicted Smokers
- C. Vulnerable Populations Will Benefit from a Nicotine Reduction Policy

II. A Nicotine Content Standard Should Apply to Other Combustible Tobacco Products
- A. The Tobacco Industry Manipulates Loopholes in Product Regulation
- B. Cigars Are a Harmful and Addictive Substitute for Cigarettes
- C. Hookah (Waterpipe) Tobacco is Harmful and Addictive
- D. The rule should prohibit other changes in cigarettes that might counteract the effect of the reduction in nicotine.

III. Implementation Considerations
- A. Maximum Nicotine Level
- B. An Immediate Nicotine Content Reduction Will Have a Larger Public Health Impact than a Gradual Reduction
- C. Reducing the Nicotine Content of Combustibles Will Not Lead to Compensation
- D. FDA Must Counter Misperceptions about the Harms of Reduced Nicotine Products

IV. Technical Achievability
- A. Reducing Nicotine in Cigarettes is Technologically Feasible
- B. FDA Should Make the Effective Date of the Rule as Early as Possible.
- C. Manufacturers, Distributors, and Retailers Should Not Be Allowed to Sell Off Existing Nonconforming Inventories.
- D. FDA Should Require a Standard Method of Product Testing to Analyze Nicotine Levels.

V. Possible Countervailing Effects
- A. The Product Standard Should Prohibit the Sale or Distribution of Liquid Nicotine or Any Other Tobacco Product Designed to Supplement the Nicotine Content of Combusted Tobacco Products.
- B. Illicit Trade

VI. Other Considerations
- A. The Potential Consumer Surplus or Utility Loss from the Removal of Nicotine from Combusted Tobacco Products is Minimal in Light of the Availability of Other Sources of Nicotine and the Continued Availability of Tobacco Products.
- B. FDA Should Consider Externalities, Such as the Reduction in Secondhand Smoke, in Evaluating the Consequences of the Rule
- C. Post-market Surveillance is Critical

The AMA also submitted individual comments (see Appendix) calling on the FDA to:

> create a non-addictive nicotine level standard for all tobacco products, not just cigarettes. This includes smokeless tobacco, electronic nicotine delivery systems (ENDS), 'heat not burn products,' and any other tobacco products containing nicotine for recreational use. If FDA reduces nicotine content in combustible tobacco products without already having a regulatory strategy in place that appropriately addresses ENDS, it will miss a critical opportunity to reduce overall nicotine addiction and use of tobacco products. Comprehensive and specific regulations are necessary to prevent new products that may circumvent the nicotine level requirement.

DISCUSSION

Several studies have been released on the issue of low nicotine cigarette product standards since the AMA submitted comments to the FDA regarding a tobacco product standard for nicotine. These studies have largely been consistent with the AMA's comments or have addressed gaps where information was not previously available. One study found that when nondaily smokers switch to very low nicotine content cigarettes, they reduced their cigarette consumption by 51 percent, though they did not necessarily stop smoking.[2] A study looking at whether smoking intensity increased when intermittent smokers switched to very low nicotine content cigarettes found that smoking intensity decreased.[3] Another study examined the effects of immediate vs. gradual reduction in nicotine content to very low levels and as compared with usual nicotine level cigarettes on biomarkers of toxicant exposure. Among smokers, immediate reduction of nicotine in cigarettes (to 0.4 mg of nicotine per gram of tobacco) led to significantly greater decreases in biomarkers of smoke exposure across time compared with gradual reduction (from 15.5 mg to 0.4 mg of nicotine per gram of tobacco cigarettes with 5 monthly dose changes) or a control group (maintenance on 15.5 mg of nicotine per gram of tobacco cigarettes), with no significant differences between gradual reduction and control.[4]

A search on clinicaltrials.gov indicates that there are a number of clinical trials underway that will provide additional information on very low nicotine content cigarettes and nicotine product standards.

CURRENT AMA POLICY

Existing AMA policy acknowledges that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette. Policy also recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal and supports the use of FDA-approved tools for smoking cessation. The AMA supports the FDA's regulatory authority over tobacco products and encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness.

RECOMMENDATION

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 431-A-18 and the remainder of the report be filed:

1. That AMA Policy H-495.988, "FDA Regulation of Tobacco Products" be amended by addition to read as follows:

   1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale,

distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA’s progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy. (Modify Current HOD Policy)

2. That American Medical Association Policy H-495.972, “Electronic Cigarettes, Vaping, and Health” be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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1. Food and Drug Administration, Tobacco Product Standard for Nicotine Level of Combusted Cigarettes. 83 FR 11818, pgs. 11818-11843. Available at: https://www.federalregister.gov/documents/2018/03/16/2018-05345/tobacco-product-standard-for-nicotine-level-of-combusted-cigarettes. Accessed March 1, 2019

2. Shiffman S, Kurland BF, Scholl SM, Mao JM. Nondaily Smokers' Changes in Cigarette Consumption With Very Low-Nicotine-Content Cigarettes: A Randomized Double-blind Clinical Trial. *JAMA Psychiatry*.2018;75(10):995–1002.

3. Shiffman S, Mao JM, Kurland BF, Scholl SM. Do non-daily smokers compensate for reduced cigarette consumption when smoking very-low-nicotine-content cigarettes? *Psychopharmacology* (Berl). 2018; 235(12):3435-3441.

4. Hatsukami, D. K., Luo, X., Jensen, J. A., Al'Absi, M., Allen, S. S., Carmella, S. G., Donny, E. C. Effect of immediate vs gradual reduction in nicotine content of cigarettes on biomarkers of smoke exposure a randomized clinical trial. *JAMA - Journal of the American Medical Association*. 2018; 320(9): 880-891.

July 16, 2018

Dockets Management Staff [HFA-305]
Food and Drug Administration
5630 Fishers Lane, Room 1061
Rockville, MD 20852

Re: Docket No. FDA-2017-N-6189, Tobacco Product Standard for Nicotine Level of Combusted Cigarettes

The undersigned organizations submit these comments in the above-designated docket regarding the FDA's Advance Notice of Proposed Rulemaking on a Tobacco Product Standard for Nicotine Level of Combusted Cigarettes.

Introduction

For decades, researchers have agreed that nicotine is the fundamental addictive agent in tobacco, leading the U.S. Surgeon General to affirmatively conclude in the 1988 report, *The Health Consequences of Smoking: Nicotine Addiction*, that, "nicotine is the drug in tobacco that causes addiction."[1] Now, strong scientific evidence also demonstrates that reducing the nicotine

[1] U.S. Department of Health and Human Services (HHS). *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General*. 1988.

content to a very low level can reduce smoking and nicotine addiction.[2] Reducing nicotine levels in combustible tobacco products provides enormous potential to accelerate progress in preventing and reducing smoking and the death and disease it causes. We urge you to move forward with this proposal as quickly as possible.

As FDA noted in the Advance Notice of Proposed Rulemaking (ANPRM at 11822), reducing the nicotine content of cigarettes will: "(1) Give addicted users of cigarettes the choice and ability to quit more easily by reducing the nicotine to a minimally addictive or nonaddictive level and (2) reduce the risk of progression to regular use and nicotine dependence for persons who experiment with the tobacco products covered by the standard." Making cigarettes minimally or non-addictive will prevent most kids from ever becoming regular smokers and will increase the number of smokers who make a quit attempt and successfully quit. The FDA estimates that this proposal would prevent more than 33 million youth and young adults from becoming regular smokers this century, prompt 5 million smokers to quit within one year (rising to 13 million in five years) and save more than 8 million lives by the end of the century. [3] The impact of this policy would be historic. There are few actions FDA could take that would prevent as many young people from smoking and save as many lives.

It is important, however, that FDA consider a nicotine product standard as part of a comprehensive set of regulatory policies to curb the use of combustible tobacco products. Thus, moving toward adoption of such a standard would not obviate the need to implement, as soon as possible, proposals that include prohibiting menthol in cigarettes and characterizing flavors in all tobacco products, as well as graphic health warnings for cigarettes. Moreover, there is, and will continue to be, a need for FDA to exercise its full authority to reduce the use of and pursue public education campaigns directed at informing the public of the health risks of all tobacco products, including those subject to the nicotine reduction proposal. Reducing nicotine in combustible products to minimally or non-addictive levels will not make those products "safe," and the public, particularly young people, need to understand that any use of these products will continue to carry substantial health risks.

I. Public Health Impact of Reducing Nicotine in Combustible Tobacco Products

Despite great progress in curbing smoking prevalence in recent years, tobacco use – primarily smoking – remains the leading cause of preventable death and disease in the United States, killing more than 480,000 Americans every year.[4] Nearly 38 million Americans currently

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[2] World Health Organization (WHO) Study Group on Tobacco Product Regulation, *Global Nicotine Reduction Strategy*, 2015, http://apps.who.int/iris/bitstream/10665/189651/1/9789241509329_eng.pdf?ua=1.

[3] Apelberg, BJ, et al., "Potential Public Health Effects of Reducing Nicotine Levels in Cigarettes in the United States," *New England Journal of Medicine*, published online March 15, 2018. See also Tobacco Product Standard for Nicotine Level of Combusted Cigarettes; Advanced Notice of Proposed Rulemaking, 83 Fed. Reg. at 11818 (March 16, 2018).

[4] HHS, *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General*, 2014.

smoke and every day about 2,300 kids try their first cigarette and another 350 additional kids become regular smokers.[5] Approximately half of continuing smokers will die prematurely as a result of their addiction, losing at least a decade of life on average compared to nonsmokers.[6]

Reducing the nicotine content in cigarettes to minimally or non-addictive levels will prevent young people who experiment from becoming addicted and save them from a lifetime of addiction, tobacco-caused disease, and premature death. It also will reduce the level of nicotine dependence in adult smokers, making it easier for them to quit. Ultimately, this will dramatically reduce the number of adult smokers. The FDA estimates that reducing nicotine levels in combusted tobacco products would prevent more than 33 million youth and young adults from initiating regular smoking by 2100. In addition, within five years, the FDA estimates it would cause 13 million smokers to quit, including five million within just the first year of implementation. Ultimately, more than 8 million lives would be saved by the end of the century.[7]

A. Reducing the Nicotine Content of Cigarettes will Help Smokers Quit

As stated by a Philip Morris researcher in 1972, "***No one has ever become a cigarette smoker by smoking cigarettes without nicotine.***"[8] Nicotine is the primary addictive agent in cigarettes.[9] According to the U.S. Surgeon General, "the addiction caused by the nicotine in tobacco smoke is critical in the transition of smokers from experimentation to sustained smoking and, subsequently, in the maintenance of smoking for the majority of smokers who want to quit."[10] Most adult smokers want to quit (nearly 70 percent) and wish they had never started (about 90 percent), but overcoming an addiction to nicotine is difficult and smokers often need to make multiple quit attempts before succeeding.[11]

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[5] CDC, "Current Cigarette Smoking Among Adults – United States, 2016," *Morbidity and Mortality Weekly Report* (*MMWR)* 67(2):53-59, January 19, 2018. https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6702a1-H.pdf; Substance Abuse and Mental Health Services Administration (SAMHSA), HHS, *Results from the 2016 National Survey on Drug Use and Health, NSDUH: Detailed Tables*, 2017. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf.

[6] HHS, *The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General*, 2014.

[7] Apelberg, BJ, et al., "Potential Public Health Effects of Reducing Nicotine Levels in Cigarettes in the United States," *New England Journal of Medicine*, published online March 15, 2018. See also Tobacco Product Standard for Nicotine Level of Combusted Cigarettes; Advanced Notice of Proposed Rulemaking, 83 Fed. Reg. at 11818 (March 16, 2018).

[8] Philip Morris, Dunn,W Jr., "Motives And Incentives In Cigarette Smoking"; R107. 1972. https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/jspf0085. For additional industry quotes on nicotine, see Campaign for Tobacco-Free Kids fact sheet, "Tobacco Company Quotes: Nicotine as a Drug," https://www.tobaccofreekids.org/research/factsheets/pdf/0009.pdf.

[9] HHS, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*, 2010.

[10] HHS, *The Health Consequences of Smoking—50 Years of Progress, A Report of the Surgeon General*, 2014. See also, HHS, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*, 2010, http://www.ncbi.nlm.nih.gov/books/NBK53017/.

[11] Babb, S, et al., "Quitting Smoking Among Adults—United States, 2000—2015," *MMWR* 65:1457–1464, 2017. Fong, G., et al., "The Near-Universal Experience of Regret Among Smokers in Four Countries: Findings from

Research demonstrates that significantly reducing nicotine levels holds great promise for accelerating progress in reducing smoking. Scientific evidence establishes that it is possible to lower nicotine levels in ways that dramatically reduce dependence. Based on a comprehensive review of the evidence, the World Health Organization Study Group on Tobacco Product Regulation concluded that reducing nicotine content in cigarettes could:[12]

- Reduce smoking acquisition and progression to addiction;
- Increase cessation and reduce relapse; and, ultimately,
- Reduce smoking prevalence.

The first large scale clinical trial of very low nicotine content (VLNC) cigarettes in the US, conducted in 2013-2014, randomly assigned over 800 smokers to use their usual brand of cigarettes or cigarettes with varying levels of nicotine for six weeks. Smokers assigned to smoke cigarettes with lower nicotine content smoked fewer cigarettes, reduced their exposure and dependence to nicotine, and reduced cravings, compared to the control group. The same study also found that those smoking cigarettes with the lowest nicotine content (0.4 mg/g) were twice as likely to report trying to quit in the 30 days after the study ended compared to those smoking cigarettes with 15.8 mg/g (34% vs. 17%). Smokers assigned to smoke cigarettes with 2.4 mg/g nicotine or less smoked between 23 and 30 percent fewer cigarettes per day at six-week follow-up compared to smokers assigned to smoke cigarettes with 15.8 mg/g nicotine. [13]

Other smaller studies have shown that use of reduced nicotine cigarettes leads to reductions in smoking, nicotine dependence, and biomarkers of exposure to nicotine and other toxins.[14] Research also shows that reduced nicotine cigarettes increase abstinence among smokers trying to quit.[15] For example, a 2009-2010 randomized controlled trial in New Zealand assigned over 1400 smokers seeking treatment from the Quitline to receive VLNC cigarettes with standard Quitline care (nicotine replacement therapy and behavioral counseling) for six

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the International Tobacco Control Policy Evaluation Survey," *Nicotine & Tobacco Research*, Vol. 6, Supplement 3, December 2004.

[12] WHO, *Global Nicotine Reduction Strategy*, 2015.

[13] Donny, EC, et al., "Randomized trial of reduced-nicotine standards for cigarettes," *New England Journal of Medicine*, 373: 1340-1349, 2015.

[14] See e.g., Donny EC, et al. Smoking in the absence of nicotine: behavioral, subjective and physiological effects over 11 days. *Addiction* 2007; 102: 324-34. Benowitz NL, et al., Nicotine and carcinogen exposure with smoking of progressively reduced nicotine content cigarette. *Cancer Epidemiol Biomarkers Prev* 2007; 16: 2479-85. Benowitz NL, et al., Urine nicotine metabolite concentrations in relation to plasma cotinine during low-level nicotine exposure. *Nicotine & Tobacco Research* 2009; 11: 954-60. Benowitz NL, et al. Smoking behavior and exposure to tobacco toxicants during 6 months of smoking progressively reduced nicotine content cigarettes. *Cancer Epidemiol Biomarkers Prev* 2012; 21: 761-9. Hatsukami DK, et al. Reduced nicotine content cigarettes: effects on toxicant exposure, dependence and cessation. *Addiction* 2010; 105: 343-55.

[15] See e.g., Walker, N, et al., "The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitine care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial," *Addiction*, 107(10): 1857-1867, 2012. McRobbie, H, et al., "Complementing the standard multicomponent treatment for smokers with denicotinized cigarettes: a randomized controlled trial," *Nicotine & Tobacco Research*, 18(5): 1134-1141, 2016.

weeks, or Quitline care alone. At 6-month follow-up, smokers who had received VLNC cigarettes were more likely to have quit smoking (33% vs. 28% seven-day point prevalence abstinence; 23% vs. 15% continuous abstinence).[16] This evidence suggests that VLNC cigarettes can help smokers who are making a quit attempt.

B. Reducing the Nicotine Content of Combustibles Will Prevent Kids from Becoming Addicted Smokers

The FDA noted in the ANPRM (at 11821, 11823-11824) the powerful addictiveness of nicotine, particularly on the adolescent brain. Tobacco use almost always begins during adolescence and adolescents are particularly vulnerable to the addictive effects of nicotine because the brain continues to develop until about age 25. Because adolescence and young adulthood are critical periods of growth and development, exposure to nicotine may have lasting, adverse consequences on brain development.[17] The parts of the brain most responsible for decision making, impulse control, sensation seeking, and susceptibility to peer pressure continue to develop and change through young adulthood.[18] As a result, nicotine exposure during adolescence may result in impaired attention and memory, problems with learning, reduced self-control and anxiety.[19] Nicotine not only harms the adolescent brain, but is critical to the progression to regular smoking behavior, reinforcing a behavior that exposes smokers to the harmful chemicals responsible for tobacco-related death and disease. While ethical considerations limit the possibilities for research of VLNC on adolescents, a secondary analysis of data from the randomized controlled trial described earlier (Donny et al., 2015), found that young adults smoked fewer VLNC cigarettes per day than older adults after two weeks in the trial, suggesting that younger populations may be more sensitive and responsive to a nicotine reduction policy.[20]

C. Vulnerable Populations Will Benefit from a Nicotine Reduction Policy

As smoking rates have declined nationally, smoking has become increasingly concentrated among certain vulnerable populations. According to data from the 2012-2014

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[16] Walker, N, et al., "The combined effect of very low nicotine content cigarettes, used as an adjunct to usual Quitine care (nicotine replacement therapy and behavioural support), on smoking cessation: a randomized controlled trial," *Addiction*, 107(10): 1857-1867, 2012.

[17] HHS. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General* , 2014; Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015.

[18] Institute of Medicine, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*, Washington, DC: The National Academies Press, 2015.

[19] England, LJ, et al., "Nicotine and the Developing Human: A Neglected Element in the Electronic Cigarette Debate." *American Journal of Preventive Medicine*, 2015; Goriounova NA, Mansvelder HD, "Short-and Long-Term Consequences of Nicotine Exposure During Adolescence for Prefrontal Cortex Neuronal Network Function," *Cold Spring Harbor Perspectives in Medicine*, 2012; Steinberg, Laurence, "Should the Science of Adolescent Brain Development Inform Public Policy?," Issues in Science and Technology, Volume XXVIII, Issue 3, Spring 2012.

[20] Cassidy, RN, et al., "Age moderates smokers' subjective response to very low nicotine content cigarettes: evidence from a randomized controlled trial," *Nicotine & Tobacco Research*, published online April 28, 2018.

National Survey on Drug Use and Health (NSDUH), 33.3% of adults with any mental illness were current (past month) smokers, compared to 20.7% of adults without any mental illness.[21] Further, about three out of ten smokers (29.5%) have a mental illness.[22] Additional national data from the National Health Information Survey (NHIS) of adults ages 18 and over find that 35.8 percent of adults with serious psychological distress are current smokers, compared to 14.7 percent of adults without serious psychological distress.[23]

It is important to ensure that a nicotine reduction policy would not exacerbate existing disparities by causing negative side effects for those with affective disorders. Fortunately, the evidence to date indicates that these populations do in fact benefit from VLNC cigarettes. A secondary analysis of data from the randomized controlled trial described earlier (Donny et al., 2015) found that smokers with elevated depressive symptoms at baseline who were assigned to smoke VLNC cigarettes did in fact show lower smoking rates and nicotine dependence, without worsening depressive symptoms.[24] Preliminary *ad libitum* smoking session studies have also found that VLNC cigarettes do not affect psychiatric symptoms in schizophrenic patients and result in a reduction in cigarette craving, total puff volume, and nicotine withdrawal symptoms.[25] VLNC cigarettes also have reduced addiction potential in other vulnerable populations, including smokers with opioid dependence and socioeconomically disadvantaged women, without substantial impact on withdrawal, craving, or compensatory smoking.[26]

II. A Nicotine Content Standard Should Apply to Other Combustible Tobacco Products (***ANPRM Section A, Scope, Question 1***)

To realize the potential public health benefits of a nicotine product standard, FDA must extend that standard beyond cigarettes, to other combustible tobacco products, particularly those that serve as or might serve as substitutes for cigarettes, such as roll-your-own tobacco (RYO)

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[21] Lipari, R.N. and Van Horn, S.L. "Smoking and mental illngess among adults in the United States." *The CBHSQ Report:* March 30, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD, https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html.

[22] CDC, "Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years with Mental Illness—United States, 2009-2011," *MMWR*, 62(5): 81-87, 2013. NSDUH defines any mental illness as "having a mental, behavioral, or emotional disorder, excluding developmental and substance use disorders, in the past 12 months" and defines current smoking as "smoking all or part of a cigarette within the 30 days preceding the interview."

[23] CDC, "Current Cigarette Smoking Among Adults – United States, 2016," *MMWR* 67(2):53-59, January 19, 2018. Serious psychological distress defined by the Kessler psychological distress scale. Across all age groups, current cigarette smoking increased significantly for each of the four categories of psychological distress (no, low, moderate, high).

[24] Tidey, JW, et al., "Effects of 6-week use of reduced-nicotine content cigarettes in smokers with and without elevated depressive symptoms," *Nicotine & Tobacco Research*, 19(1): 59-67, 2017.

[25] Tidey, JW, et al., "Smoking topography characteristics of very low nicotine contenet cigarettes, with and without nicotine replacement, in smokers with schizophrenia and controls," *Nicotine & Tobacco Research*, 18(9): 1807-1812, 2016. Tidey, JW, et al., "Separate and combined effects of very low nicotine cigarettes and nicotine replacement in smokers with schizophrenia and controls," *Nicotine & Tobacco Research*, 15(1): 121-129, 2013.

[26] Higgins, ST, et al., "Addiction potential of cigarettes with reduced nicotine in populations with psychiatric disorders and other vulnerabilities to tobacco addiction," *JAMA Psychiatry*, 74(1): 1056-1064, 2017

and smaller cigars. As FDA noted in the ANPRM (at 11825), other combusted tobacco products have similar negative health effects to cigarettes and cigarette smokers may switch to these products if the nicotine reduction standard is only applied to cigarettes. Extending the proposed nicotine reduction policy to other combustible tobacco products will limit the possibility that cigarette smokers will switch to other dangerous combustible products. Furthermore, extending the nicotine standard to these products, which are often flavored and popular among youth, will prevent youth experimenters from becoming addicted to these and other tobacco products. It will also prevent tobacco manufacturers from circumventing a nicotine content standard in cigarettes by marketing and developing non-cigarette substitutes like the small flavored cigars the industry introduced after flavored cigarettes were removed from the market.

A. The Tobacco Industry Manipulates Loopholes in Product Regulation

History shows that the tobacco industry is adept in manipulating loopholes in tobacco control regulations. Tobacco companies have skillfully modified their products to circumvent regulation and minimize the effectiveness of policies designed to reduce tobacco use. For example, in the 1960s and 1970s, "little cigars" that look like cigarettes were developed to avoid the ban on broadcast advertising of cigarettes and higher cigarette taxes.[27]

More recently, manufacturers have modified their products to be classified as cigars rather than cigarettes to evade the TCA's prohibition of characterizing flavors in cigarettes[28] and the use of misleading cigarette descriptors such as "light" and "low."[29] The 2012 Surgeon General's report, *Preventing Tobacco Use Among Youth and Young Adults*, noted that flavored cigarettes such as Sweet Dreams re-emerged as Sweet Dreams flavored cigars after the federal restriction on flavored cigarettes went into effect.[30] In October 2009, U.S. Representatives Henry Waxman and Bart Stupak sent letters to two flavored cigarette companies, Cheyenne International and Kretek International, that began making little cigars shortly after the federal flavored cigarette ban went into effect.[31] Rep. Waxman discovered that Kretek International

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[27] Delnevo, CD & Hrywna, M, "A Whole 'Nother Smoke' or a Cigarette in Disguise: How RJ Reynolds Reframed the Image of Little Cigars," *American Journal of Public Health* 97(8):1368-75, August 2007.

[28] Delnevo, CD, et al., "Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation," *Tobacco Control* 26(3):349-354, May 2017. Delnevo, CD & Hrywna, M, "Clove cigar sales following the US flavoured cigarette ban," *Tobacco Control* 24(e4):e246-50, December 2015.

[29] See generally, Campaign for Tobacco-Free Kids, *Not Your Grandfather's Cigar: A New Generation of Cheap and Sweet Cigars Threatens a New Generation of Kids*, March 13, 2013, at 14-15 (*Not Your Grandfather's Cigar*), http://www.tobaccofreekids.org/content/what_we_do/industry_watch/cigar_report/2013CigarReport_Full.pdf.

[30] HHS, *Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012, http://www.cdc.gov/Features/YouthTobaccoUse/.

[31] House Committee on Energy & Commerce, "Energy and Commerce Committee Requests Information on Sales and Marketing of Flavored Tobacco Products," October 2, 2009, accessed April 18, 2012 at http://democrats.energycommerce.house.gov/index.php?q=news/energy-and-commerce-committee-requests-information-on-sales-and-marketing-of-flavored-tobacco-p.

intentionally changed its cigarettes to cigars to exploit a loophole in the TCA.[32] In December 2016, the FDA issued warning letters to four tobacco manufacturers – Swisher International, Inc., Cheyenne International LLC, Prime Time International Co. and Southern Cross Tobacco Company Inc. – for marketing and selling fruit-flavored cigarettes labeled as cigars, in violation of the Tobacco Control Act.[33]

Tobacco companies have also added weight to filters to allow for reclassification of their cigarettes or "little cigars" as "large cigars" subject to lower federal excise taxes.[34] Moreover, tobacco companies intentionally designed and marketed little cigars as similar products to cigarettes to appeal to cigarette smokers.[35]

FDA recognized reclassification as a potential problem in its Final Regulatory Impact Analysis of the final deeming rule when it stated, "Deeming all tobacco products, except accessories of a newly deemed tobacco product, to be subject to chapter IX of the FD&C Act would be the necessary first step to rectify an institutional failure in which tobacco products that are close substitutes are not regulated by FDA in a like manner. …Historically, when products have been taxed or regulated differently, substitutions have occurred."[36]

There is little doubt that tobacco companies will promote cigars and potentially other combustible tobacco products as alternatives to cigarettes if the nicotine policy does not address other forms of combustible tobacco. Failure to extend the prohibition to other combusted tobacco products would greatly limit the chances for the regulation to accomplish its goal.

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[32] Representative Henry A. Waxman, "Rep. Waxman Urges FDA to Ban Clove-Flavored Cigars," Letter to FDA Commissioner Margaret Hamburg, March 28, 2011, accessed April 18, 2012 at http://democrats.energycommerce.house.gov/index.php?q=news/rep-waxman-urges-fda-to-ban-clove-flavored-cigars.

[33] FDA, Center for Tobacco Products, "FDA takes action against four tobacco manufacturers for illegal sales of flavored cigarettes labeled as little cigars or cigars," December 9, 2016, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm532563.htm.

[34] Delnevo, CD, et al., "Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation," *Tobacco Control* 26(3):349-354, May 2017. Campaign for Tobacco-Free Kids, *Not Your Grandfather's Cigar: A New Generation of Cheap and Sweet Cigars Threatens a New Generation of Kids*, March 13, 2013, at 14-15 (*Not Your Grandfather's Cigar*), http://www.tobaccofreekids.org/content/what_we_do/industry_watch/cigar_report/2013CigarReport_Full.pdf at 15.

[35] Delnevo, CD, et al., "Close, but no cigar: certain cigars are pseudo-cigarettes designed to evade regulation," *Tobacco Control* 26(3):349-354, May 2017.

[36] FDA, *Deeming Tobacco Products to be Subject to the Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Regulations Restricting the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Product Packages and Advertisements, Final Regulatory Impact Analysis; Final Regulatory Flexibility Analysis; Unfunded Mandates Reform Act Analysis*, May 2016, at 60-61, https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/EconomicAnalyses/UCM500254.pdf.

B. Cigars Are a Harmful and Addictive Substitute for Cigarettes

There is no rational basis for reducing nicotine levels in cigarettes, while leaving cigars highly addictive. Cigars pose an increased risk of disease and addiction. Cigar smoke contains many of the same harmful constituents as cigarette smoke and may have higher levels of several harmful compounds. Cigar smoking causes cancer of the oral cavity, larynx, esophagus and lung and some cigar smokers are at increased risk for heart disease, chronic obstructive pulmonary disease (COPD) and an aortic aneurysm.[37]

Furthermore, cigars contain nicotine and can deliver nicotine at levels high enough to produce dependence among cigar smokers.[38] Nicotine content is not always associated with the size of the cigar. A study found that some cigarillos had higher levels of free nicotine per mass compared to large cigars, leading the authors to state, "consumers smoking the same brand of cigar may unintentionally be exposed to varying doses of nicotine and potentially other smoke constituents."[39]

Nicotine levels in cigars vary by product and the type of tobacco used. One full-size cigar may contain as much tobacco as a whole pack of cigarettes and thus contains much more nicotine than one cigarette. Cigarettes contain an average of about 10-15 mg of nicotine;[40] many popular brands of larger cigars contain between 100 and 200 mg.[41]

The amount of nicotine delivered to the cigar smoker depends on various factors, such as how the cigar is smoked, the number of puffs taken, and the degree of inhalation.[42] The high pH of cigar smoke means that the nicotine is in its free, unprotonated form, making it easily

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[37] National Cancer Institute (NCI), *Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9*, 1998, http://cancercontrol.cancer.gov/Brp/tcrb/monographs/9/m9_complete.pdf.

[38] Henningfield, JE, et al., "Nicotine concentration, smoke pH and whole tobacco aqueous pH of some cigar brands and types popular in the United States," *Nicotine & Tobacco Research* 1(2):163-168, 1999, at 166. NCI Monograph 9, at 186, 191. Baker, F, et al., "Health Risks Associated With Cigar Smoking," *Journal of the American Medical Association* 284(6):735-740, 2000, at 737. Fabian, LA, et al., "*Ad lib* Smoking of Black & Mild Cigarillos and Cigarettes," *Nicotine & Tobacco Research* 14(3):368-371, March 2012, at 370. Goel, R, et al., "A Survey of Nicotine Yields in Small Cigar Smoke: Influence of Cigar Design and Smoking Regimens," *Nicotine & Tobacco Research*, published online September 15, 2017. Pickworth, WB, et al., "Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure," *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at S79. Claus, ED, "Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking," *Tobacco Regulatory Science* 4(1):548-561, 2018, at 558.

[39] Koszowski, B, et al., "Nicotine Content and Physical Properties of Large Cigars and Cigarillos in the United States," *Nicotine & Tobacco Research* 20(3):393-398, 2018, at 395, 397.

[39] American Cancer Society, "Is Any Type of Smoking Safe?" March 6, 2018, https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/is-any-type-of-smoking-safe.html.

[40] Benowitz, N and Henningfield, J.,"Reducig the nicotine content to make cigarettes less addictive," Tobacco Control, 22:i14-i17, 2013.

[41] American Cancer Society, "Is Any Type of Smoking Safe?" March 6, 2018, https://www.cancer.org/cancer/cancer-causes/tobacco-and-cancer/is-any-type-of-smoking-safe.html.

[42] Henningfield, JE, et al., "Nicotine concentration, smoke pH and whole tobacco aqueous pH of some cigar brands and types popular in the United States," *Nicotine & Tobacco Research* 1(2):163-168, 1999, at 165. NCI Monograph 9, at 186.

absorbed through the oral mucosa, even if the users do not fully inhale the smoke.[43] A leading review of the science of cigar smoking concluded that, "[c]igars are capable of providing high levels of nicotine at a sufficiently rapid rate to produce clear physiological and psychological effects that lead to dependence, even if the smoke is not inhaled."[44]

Authors of a recent study looking at a variety of cigar products noted, "it is clear that all cigar products delivered significant and addictive quantities of nicotine and CO – findings that support the rationale for their regulation."[45]

Exempting cigars from a reduced nicotine standard is likely to lead current cigarette smokers to switch to cigars or use both cigarettes and cigars to satisfy their need for nicotine. It is not uncommon for cigarette smokers to replace cigarettes with cigars.[46] According to 2013-2014 data from the Population Assessment of Tobacco and Health (PATH) study, nearly 30 percent of premium cigars smokers were former cigarette smokers, as were 10 to 15 percent of non-premium cigar users (non-premium large cigars, cigarillos, filtered cigars).[47] The 2012-2013 National Adult Tobacco Survey (NATS) found similar results - 23 percent of premium cigar smokers, 15.3 percent of cigarillo/mass market cigar smokers, and 12.3 percent of little filtered cigar smokers were former cigarette smokers.[48]

Secondary cigar smokers, those who smoked cigarettes before smoking cigars, often inhale and smoke more than cigar smokers who have never used cigarettes (primary cigar smokers).[49] Because of their tendency to inhale the smoke, secondary cigar smokers can take in

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[43] NCI Monograph 9, at ii, 4, 11, 97, 183, 191.

[44] Baker, F., et al., "Health Risks Associated With Cigar Smoking," *Journal of the American Medical Association*, 284(6): 735-740, 2000, at 737.

[45] Pickworth, WB, et al., "Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure," *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at S79.

[46] Corey, CG, et al., "U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14," *Nicotine & Tobacco Research*, published online September 15, 2017. Cohn, A, et al., "The Other Combustible Products: Prevalence and Correlates of Little Cigar/Cigarillo Use Among Cigarette Smokers," *Nicotine & Tobacco Research* 17(12):1473-1481, 2015.

[47] Corey, CG, et al., "U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14," *Nicotine & Tobacco Research*, published online September 15, 2017.

[48] Corey, CG, et al., "Little Filtered Cigar, Cigarillo, and Premium Cigar Smoking Among Adults — United States, 2012-2013," *MMWR* 63(30):650-654, August 1, 2014, at 652, 653. The study authors defined premium cigar smokers as "those reporting their usual cigar did not have a filter or tip and the name of their usual brand was a brand name of a hand-rolled cigar or a cigar described by the manufacturer or merchant as containing high-grade tobaccos in the filler, binder, or wrapper."

[49] Claus, ED, "Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking," *Tobacco Regulatory Science* 4(1):548-561, 2018. Rosenberry, ZR, Pickworth, WB, & Koszowski, B, "Large Cigars: Smoking Topography and Toxicant Exposure," *Nicotine & Tobacco Research* 20(2):183-191, 2018, at 189.

more nicotine compared to primary cigar smokers.[50] They also show higher scores of nicotine dependence than primary cigar smokers.[51]

PATH data from 2013-2014 show that a fair number of cigar smokers also smoke cigarettes (dual use): nearly 30 percent (29.9%) of premium cigar users and more than half of users of other cigar products (non-premium large cigars, cigarillos, filtered cigars) were also current cigarette smokers.[52] The 2012-2013 NATS reported similar results, with 35.1 percent of premium cigar smokers, 58.3 percent of cigarillo/mass market cigar smokers, and 75.2 percent of little filtered cigar smokers dual using with cigarettes.[53] Cigarette use in the past 30 days can predict current cigar use.[54]

Like secondary cigar smokers, dual users tend to inhale cigar smoke, compared to cigar smokers who never smoked cigarettes.[55] Dual users smoke cigars in such a way as to obtain a satisfactory level of nicotine,[56] but they also show greater levels of dependence than exclusive cigar users.[57] Adolescents who ever used cigars products (cigars, cigarillos, or little cigars) or used them in the past 30 days reported more frequent cigarette smoking in the past month, more daily smoking in the past month, and, notably, higher levels of nicotine dependence compared to adolescents who did not use cigar products.[58]

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[50] NCI Monograph 9, at 94.

[51] Claus, ED, "Use Behaviors, Dependence, and Nicotine Exposure Associated with Ad Libitum Cigar Smoking," *Tobacco Regulatory Science* 4(1):548-561, 2018.

[52] Corey, CG, et al., "U.S. adult cigar smoking patterns, purchasing behaviors, and reasons for use according to cigar type: Findings from the Population Assessment of Tobacco and Health (PATH) Study, 2013-14," *Nicotine & Tobacco Research*, published online September 15, 2017.

[53] Corey, CG, et al., "Little Filtered Cigar, Cigarillo, and Premium Cigar Smoking Among Adults — United States, 2012-2013," *MMWR* 63(30):650-654, August 1, 2014, at 652, 653. The study authors defined premium cigar smokers as "those reporting their usual cigar did not have a filter or tip and the name of their usual brand was a brand name of a hand-rolled cigar or a cigar described by the manufacturer or merchant as containing high-grade tobaccos in the filler, binder, or wrapper."

[54] Cullen, J, et al., "Seven-Year Patterns in US Cigar Use Epidemiology Among Young Adults Aged 18–25 Years: A Focus on Race/Ethnicity and Brand," *American Journal of Public Health* 101(10):1955-62, October 2011, at 1958-1959.

[55] Baker, F, et al., "Health Risks Associated With Cigar Smoking," *Journal of the American Medical Association* 284(6):735-740, 2000, at 737. NCI Monograph 9, at 185.

[56] Pickworth, WB, et al., "Dual Use of Cigarettes, Little Cigars, Cigarillos, and Large Cigars: Smoking Topography and Toxicant Exposure," *Tobacco Regulatory Science* 3(Suppl 1):S72-S83, April 2017, at 7. Rosenberry, ZR, Pickworth, WB, & Koszowski, B, "Large Cigars: Smoking Topography and Toxicant Exposure," *Nicotine & Tobacco Research* 20(2):183-191, 2018, at 189.

[57] Rostron, BL, Schroeder, MJ, & Ambrose, BK, "Dependence symptoms and cessation intentions among US adult daily cigarette, cigar, and e-cigarette users, 2012-2013," *BMC Public Health* 16:814, 2016.

[58] Schuster, RM, Hertel, AW, & Mermelstein, R, "Cigar, Cigarillo, and Little Cigar Use Among Current Cigarette-Smoking Adolescents," *Nicotine & Tobacco Research* 15(5):925-931, May 2013, at 927-928.

C. Hookah (Waterpipe) Tobacco is Harmful and Addictive (***ANPRM Section A, Question 4)***

In a typical waterpipe session, smokers are subjected to up to more than twice the nicotine exposure as the smoker of a single cigarette.[59] Research shows that waterpipe tobacco use is associated with nicotine dependence, including experiences of withdrawal and difficulty quitting, at least among some users.[60] Given its addiction potential, waterpipe tobacco should not be excluded from a nicotine product standard.

Studies have shown that hookah smoke contains many of the toxins and carcinogens found in cigarettes.[61] Some of these harmful components are in gaseous form and others are particulates. At least 82 toxicants and carcinogens have been identified in waterpipe tobacco smoke, including tobacco-specific nitrosamines (TSNAs), polycyclic aromatic hydrocarbons (PAHs), and heavy metals.[62] In addition, the aerosol contains the toxins and carcinogens from the burning of the charcoal, including carbon monoxide. A recently published meta-analysis that analyzed 17 studies of waterpipe tobacco smoking found that a single waterpipe tobacco smoking session was associated with carbon monoxide exposure equivalent to more than half a pack of cigarettes and exposure to tar equivalent to more than two full packs of cigarettes.[63] None of these harmful components are eliminated by the passage of the smoke through the water and many of these harmful substances are delivered to the user's lungs.

According to the CDC, using a waterpipe to smoke tobacco poses serious health risks to smokers and others exposed to the smoke from the waterpipe tobacco.[64] Waterpipe tobacco use is linked to many of the same adverse health effects as cigarette smoking, such as lung, bladder and oral cancers and heart disease.[65] Other documented long-term effects include impaired

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[59] Primack B, et al. 2016. HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. Eissenberg, T and Shihadeh, A., 2009. Maziak, W, et al., "CO exposure, puff topography, and subjective effects in waterpipe tobacco smokers," *Nicotine & Tobacco Research*, 11(7): 806-811, 2006.

[60] Aboaziza, E and Eissenberg, T., "Waterpipe tobacco smoking: what is the evidence that it supports nicotine/tobacco dependence?" *Tobacco Control*, published online December 9, 2014.

[61] HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012.

[62] Ward, KD, et al., "The waterpipe: an emerging epidemic in need of action," *Tobacco Control*, 24(S1): i1-i2, 2015. Sepetdijian, E, et al., "Measurement of 16 Polycyclic Aromatic Hydrocarbons in Narghile Waterpipe Tobacco Smoke," *Food and Chemical Toxicology*, 46: 1582-1590, 2008. Schubert, J., et al., "Mainstream Smoke of the Waterpipe: Does this Environmental Matrix Reveal as Significant Source of Toxic Compounds?" *Toxicology Letters*, 205(3): 279-284, 2011. Jacob, P., et al. "Nicotine, Carbon Monoxide and Carcinogen Exposure After a Single Use of a Water Pipe," *Cancer Epidemiology, Biomarkers, & Prevention*, 20: 2345-2353, 2011.

[63] Primack B, et al. Systematic review and meta-analysis of inhaled toxicants from waterpipe and cigarette smoking. *Public Health Reports* Jan. 2016. See also, HHS, Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General, 2012. Eissenberg, T and Shihadeh, A. "Waterpipe tobacco and cigarette smoking: direct comparison of toxicant exposure," *American Journal of Preventive Medicine*, 37(6): 518-523, 2009. Maziak, W, et al., "CO exposure, puff topography, and subjective effects in waterpipe tobacco smokers," *Nicotine & Tobacco Research*, 11(7): 806-811.

[64] Centers for Disease Control and Prevention. "Hookahs." Available at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/hookahs/. Accessed March 4, 2016.

[65] HHS, *Prevention Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General*, 2012. Knishkowy B, Amitai, Y. "Waterpipe (narghile) smoking: an emerging health risk behavior," *Pediatrics* 2005.

pulmonary function, chronic obstructive pulmonary disease, esophageal cancer and gastric cancer.[66] As a result of exposure to the dangerous chemicals in waterpipe tobacco smoke, research shows that even short-term waterpipe tobacco use is associated with acute health effects, including increased heart rate, blood pressure, reduced pulmonary function and carbon monoxide intoxication.[67] In a 2015 report, the World Health Organization Study group on tobacco product regulation surveyed the research to date and corroborated these findings.[68]

D. The rule should prohibit other changes in cigarettes that might counteract the effect of the reduction in nicotine. (*ANPRM Section B, Question 3)*

FDA notes that in addition to nicotine, other substances contained in cigarettes might also have the potential to produce dependence and be addictive and asks whether a proposed rule should establish maximum levels for such substances. It is important for FDA to establish a rule that prohibits any change in products subject to the rule that has the effect of diluting or offsetting the effect produced by the reduction in nicotine. Section 910 of the Tobacco Control Act prohibits tobacco product manufacturers from modifying tobacco products in the absence of a marketing order from FDA. Any product standard establishing a maximum level of nicotine in tobacco products should explicitly prohibit manufacturers from making other changes in a tobacco product with the effect of diluting or offsetting the reduction in dependence produced by reducing the nicotine content of such product.

III. Implementation Considerations

A. Maximum Nicotine Level (*ANPRM Section B, Question 1*)

When establishing a nicotine reduction level, FDA should seek a level that reduces the population harm caused by smoking. FDA should seek a level that prevents new users from developing dependence and stops the transition from experimental to regular use. The level should also reduce dependence among current users and make it easier for them to stop smoking. Because of variations in sensitivity to nicotine and the risk of dependence across individuals, to minimize the risk of dependence on a population-wide basis, FDA should set the maximum allowable nicotine at a level that produces the greatest reduction in dependence. To date, the research indicates that a nicotine content of 0.4 mg/g or less reduces dependence, taking into account the potential for individual differences in sensitivity to nicotine, and is technically feasible.[69] It is critical that there be no compromise in setting the nicotine level because a higher

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[66] El-Zaatari, ZM, et al., "Health effects associated with waterpipe smoking," *Tobacco Control*, 24(S1): i31-i43, 2015.

[67] *Id.*

[68] World Health Organization, Study Group on Tobacco Product Regulation ("TobReg"), 2015.

[69] Donny, EC, et al., "Randomized trial of reduced-nicotine standards for cigarettes," *New England Journal of Medicine*, 373: 1340-1349, 2015

nicotine level will not produce the benefits set forth by FDA and is not supported by the scientific evidence that underpins the FDA proposal.

B. An Immediate Nicotine Content Reduction Will Have a Larger Public Health Impact than a Gradual Reduction *(ANPRM Section C)*

Research shows that an immediate nicotine content reduction will have a greater public health benefit than a gradual reduction in nicotine content. A 20-week randomized controlled trial of 1200 adult smokers assigned smokers to normal nicotine content cigarettes, reduced nicotine content cigarettes (0.4 mg/g), or cigarettes with the nicotine content gradually reduced over the course of the study (from 15.8 mg/g to 0.4 mg/g). The smokers in the immediate nicotine reduction condition showed greater reduction in cigarettes per day, greater decreases in measures of dependence, higher rates and duration of abstinence, and greater reductions in biomarkers of smoke exposure.[70]

As the FDA noted in the ANPRM (at 11829), a stepped-down approach will likely facilitate more compensatory behavior by smokers. While VLNC cigarettes do not contain enough nicotine for compensation to be feasible, smokers may be able to compensate with intermediate-level nicotine cigarettes, smoking these products more intensely and exposing themselves to more toxicants.

Additionally, a stepped-down approach prolongs the implementation process and is more burdensome on farmers and manufacturers who will have to adjust to multiple nicotine content standards. Finally, this prolonged process increases the opportunities for consumers to stockpile cigarettes.

Given the stronger evidence for cessation for an immediate reduction approach and the greater implementation challenges of a stepped-down approach, it is clear that an immediate reduction in nicotine content is preferable.

C. Reducing the Nicotine Content of Combustibles Will Not Lead to Compensation (*ANPRM Section F, Question 4*)

One potential concern about reducing the nicotine level in cigarettes is that smokers may smoke more cigarettes or inhale smoke more deeply in order to obtain the nicotine fix they are accustomed to ("compensatory smoking"), which would have the unintended consequence of exposing them to even more harmful constituents. However, research to date shows that smokers in fact do not compensate in this manner when nicotine content is reduced to very low levels.[71]

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[70] Hatsukami, D. *Opening Session: Presidential Symposium Reducing Nicotine Content in Cigarettes: A Discussion of the Evidence and Policy Implications Panel Discussion*. Society for Research on Nicotine and Tobacco Annual Meeting, 2018.

[71] See e.g., Donny, EC, et al., "Randomized trial of reduced-nicotine standards for cigarettes," *New England Journal of Medicine*, 373: 1340-1349, 2015. Hatsukami, DK, et al., "Compensatory smoking from gradual and

One study that examined the number of cigarettes smoked per day (CPD), carbon monoxide exposure and cotinine levels among smokers while they smoked reduced nicotine content cigarettes, found significant decreases in CPD and cotinine levels and a decrease (non-significant) in carbon monoxide exposure compared to when they smoked their usual brand, which suggests minimal, if any, compensatory smoking.[72] Similarly, a randomized clinical trial that compared outcomes from reduced nicotine cigarettes to standard nicotine cigarettes found that smokers of reduced nicotine cigarettes inhaled less smoke per cigarette, smoked fewer cigarettes and did not have a significant increase in the level of expired carbon monoxide, indicating that smokers did not compensate for the reduction in nicotine by increasing their smoking behavior.[73] Substantially reducing nicotine in the tobacco makes it almost impossible for smokers to compensate for the lower nicotine level by smoking more cigarettes, taking more puffs on the cigarette, or inhaling more deeply.

D. FDA Must Counter Misperceptions about the Harms of Reduced Nicotine Products (***ANPRM Section, B Question 4***)

Reducing the nicotine content of tobacco products will not render them harmless; in fact, products with lower nicotine levels will remain harmful and deadly. While nicotine is the primary addictive agent in cigarettes and is not benign, the overwhelming health consequences of smoking come from the more than 7,000 chemicals and 69 cancer-causing agents produced from combusted cigarettes.[74]

Some studies of adult smokers have shown that they perceive lower nicotine cigarettes to be less harmful than average cigarettes, incorrectly linking nicotine content with risk for smoking-related disease. For example, a 2015-2016 nationally representative survey found that nearly half (47.1%) of smokers thought that smoking VLNC cigarettes would be less likely to cause cancer than smoking regular cigarettes. [75] 2015 data from the FDA's nationally representative Health Information National Trends Survey (HINTS) found that three-quarters of people either did not know the relationship between nicotine and cancer (24%) or incorrectly believe that nicotine causes cancer (49%). It also found that 30 percent of respondents thought

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immediate reduction in cigarette nicotine content," *Cancer Epidemiology, Biomarkers & Prevention*, 24: 472-476, 2015. Benowitz, NL, et al., "Smoking behavior and exposure to tobacco toxicants during 6 months of smoking progressively reduced nicotine content cigarettes," *Cancer Epidemiology, Biomarkers & Prevention* , 21: 761-769, 2012.Hatsukami, DK, et al., "Nicotine reduction revisited: science and future directions," *Tobacco Control*, 19: e1-10, 2010. Hatsukami, DK, et al., "Reduced nicotine content cigarettes: effects on toxicant exposure, dependence and cessation," *Addiction*, 105: 343-355, 2010.

[72] Hatsukami, DK, et al., "Compensatory smoking from gradual and immediate reduction in cigarette nicotine content," *Cancer Epidemiology, Biomarkers & Prevention*, 24: 472-476, 2015.

[73] Donny, EC, et al., "Randomized trial of reduced-nicotine standards for cigarettes," *New England Journal of Medicine*, 373: 1340-1349, 2015.

[74] HHS, *The Health Consequences of Smoking—50 Years of Progress, A Report of the Surgeon General*, 2014, http://www.surgeongeneral.gov/library/reports/50-years-of-progress/.

[75] Byron, JM, et al., "Public misperception that very low nicotine cigarettes are less carcinogenic," *Tobacco Control*, published online January 23, 2018.

that VLNC were less harmful than regular cigarettes.[76] In research trials, smokers assigned to use VLNC cigarettes also perceive them to be less harmful.[77]

It is critical for the FDA to carefully regulate the marketing of these products, and precede a nicotine reduction policy with public education campaigns to ensure adequate communication about the health risks of these products so as to not encourage non-smokers to experiment. Smokers should be encouraged to quit completely and be educated about the most effective ways to quit successfully.

While much of the public misunderstanding of the health effects of nicotine is to attribute undue heath risk to nicotine, FDA also needs to be careful not to go too far in the other direction. While the most prominent concern about nicotine is its addictive impact, and approved nicotine replacement therapy (NRT) products have demonstrated that at low levels in carefully calibrated doses, nicotine is not the cause of serious disease, nicotine is not benign and the health impact of its long term use at higher levels is not well understood.

IV. Technical Achievability

A. Reducing Nicotine in Cigarettes is Technologically Feasible (***ANPRM Section E***)

Research demonstrates that reducing nicotine content in cigarettes to minimally or non-addictive levels is technologically feasible. Further, as noted in the ANPRM (at 11830-11832), there is a wide range of techniques available to reduce nicotine content. As FDA notes, more than 96 percent of nicotine can be successfully extracted while achieving a product that was "subjectively rated as average in smoking characteristics."[78] Moreover, the FDA's discussion in the ANPRM identifies several chemical extraction techniques that have been used successfully to reduce the nicotine level in cigarette tobacco (ANPRM, at 11831.)

Tobacco farmers and cigarette manufacturers can reduce the nicotine content of cigarette tobacco by using existing lower-nicotine tobacco plant varieties, creating new plant varieties through genetic manipulation, using tobacco leaves from certain parts of the plant that contain

[76] O'Brien, EK, et al., "U.S. adults' addiction and harm beliefs about nicotine and low nicotine cigarettes," *Preventive Medicine*, 96: 94-100, 2017.

[77] Denlinger-Apte, RL, et al., "Low nicotine content descriptors reduce perceived health risks and positive cigarette ratings in participants using very low nicotine content cigarettes," *Nicotine & Tobacco Research*, published online January 18, 2017. Pacek, LR, et al., "Perceived nicotine content of reduced nicotine content cigarettes is a correlate of perceived health risks," *Tobacco Control*, published online July 22, 2017. 2017.

[78] 83 Fed. Reg. at 11826, citing Grubbs et al, "Process for Removal of Basic Materials," Patent No. 5,018,540, May 28, 1991.

lower nicotine content, or using extraction technology to remove nicotine from tobacco during the manufacturing process.[79]

In fact, tobacco companies have already demonstrated their proficiency in reducing the nicotine level of cigarettes.[80] In the 1980s-1990s, Philip Morris produced three brands of low-nicotine cigarettes: Merit De-Nic, Benson & Hedges De-Nic and Next. Vector Tobacco introduced Quest, a low-nicotine cigarette, in 2003. The tobacco manufacturer, 22nd Century, currently produces Spectrum, a very low nicotine U.S.-grown tobacco cigarette, which is currently used in government-funded clinical research studies. Reducing nicotine content in cigarettes to minimally or non-addictive levels is also consistent with several tobacco companies' purported missions of shifting away from combustible tobacco products by "transforming tobacco" (R.J. Reynolds)[81] and investing in a "smoke-free future" (Philip Morris).[82]

The tobacco industry's own documents also show that the industry has a long history of manipulating nicotine levels in cigarettes to make them *more* addictive. Internal company documents from as far back as the 1950s expose the tobacco industry's extensive research on the importance of nicotine and how best to deliver nicotine to smokers and optimize its effects.[83] The documents demonstrate that they have known for decades that the key to their business is creating and sustaining dependence on nicotine, and they have purposely designed their products to do this effectively and efficiently. As U.S. District Judge Gladys Kessler concluded in her landmark 2006 civil racketeering judgment against the major cigarette manufacturers, U.S. v. Philip Morris, Inc.,

> ". . . [C]igarette company defendants researched, developed, and implemented many different methods and processes to control the delivery and absorption of the optimum amount of nicotine which would create and sustain smokers' addiction. These methods and processes included, but were not limited to: altering the physical and chemical make-up of tobacco leaf blends and filler; maintaining or increasing the nicotine to tar ratio by changing filter design, ventilation and air dilution processes, and the porosity and composition of filter paper; altering smoke pH by adding ammonia to speed nicotine absorption by the central nervous system; and using other additives to increase the potency of nicotine."[84]

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79 Tengs, T.O., et al., "The AMA proposal to mandate nicotine reduction in cigarettes: a simulation of the population health impacts," *Preventive Medicine*, 40: 170-180, 2005.

80 Cigarettes with reduced nicotine are often referred to as reduced-nicotine cigarettes, very low nicotine content (VLNC) cigarettes, and de-nicotinized cigarettes.

81 RJ Reynolds, "Our vision: We will achieve market leadership by transforming the tobacco industry," accessed August 8, 2017, http://www.rjrt.com/transforming-tobacco/our-mission-and-vision/.

82 Philip Morris, "Our Manifesto: Designing a Smoke-Free Future," Accessed August 8, 2017, https://www.pmi.com/who-we-are/designing-a-smoke-free-future.

83 Wayne, GF & Carpenter, CM, "Tobacco Industry Manipulation of Nicotine Dosing," *Handbook of Experimental Psychology* (192):457-85, 2009.

84 U.S. v. Philip Morris, USA, Inc., 449 F. Supp. 2d at 383-84 (D.D.C. 2006).

Finally, producing reduced-nicotine tobacco for other combusted tobacco products should be no more difficult than producing it for cigarettes.

B. FDA Should Make the Effective Date of the Rule as Early as Possible. (*ANPRM Section E, Question 5*)

The enormous public health benefits that would result from this rule should not be postponed any longer than absolutely necessary. Postponing the effective date of the rule only means that many hundreds of thousands of smokers and prospective smokers will unnecessarily have their lives shortened by an addiction that this rule could have prevented.

As indicated above, tobacco product manufacturers are already capable of extracting nicotine from tobacco and producing VLNC cigarettes. Growing low-nicotine tobacco is only one of several methods of complying with the standard. Thus, a tobacco product standard calling for a nicotine level to be set at non-addictive levels does not necessarily require "substantial changes to the methods of farming domestically grown tobacco;" thus, the statute does not require FDA to postpone the effective date of such a standard until two years after promulgation of the rule. Moreover, industry participants will have been on notice for a significant period of time that such a requirement would be imposed and prudent companies would have been making plans to comply with such a standard. Therefore, in no event should the implementation period be more than the one-year period contemplated for all product standards under Section 907 of the Tobacco Control Act.

Tobacco product manufacturers will no doubt make self-serving claims about how difficult, expensive, and time-consuming it would be to implement such a standard. FDA should view such claims skeptically given the clear economic interest the industry has in resisting or postponing measures designed to shrink the market for a highly profitable product. The public health benefits that will be gained from implementing the rule, however, make it imperative to make the rule effective as soon as possible. These benefits far outweigh the compliance costs the industry will experience.

It is also important for the rule to be applied simultaneously to all manufacturers. The continued availability of combusted products containing conventional levels of nicotine would undermine the effectiveness of the regulatory strategy and would create an opportunity for exempted manufacturers to earn windfall profits by continuing to supply high-nicotine level cigarettes. Manufacturers should not be enabled to undercut the effectiveness of important public health initiatives merely because they are small.

C. Manufacturers, Distributors, and Retailers Should Not Be Allowed to Sell Off Existing Nonconforming Inventories. (***ANPRM Section E, Question 6***)

Products currently on the market are both deadly and highly addictive. The public health imperatives that provide the foundations for replacing these products with VLNC cigarettes are inconsistent with permitting the continued sale of non-conforming inventories beyond the effective date of the rule. The presence of non-conforming product on the market after the effective date of the rule will only dilute the effectiveness of the rule and provide a wholly unjustified windfall to companies that have stockpiled an inventory in anticipation of its promulgation. Moreover, there is no unfairness to industry participants in prohibiting the sale of such inventories after the effective date of the rule. As noted above, all industry participants will have had a substantial period of prior notice of the promulgation of such a rule and will have had many opportunities to make arrangements to deal with the consequences.

In addition, permitting industry participants to sell off existing non-conforming inventories would create a massive incentive for companies to accumulate large inventories in the anticipation that they would be able to extract windfall profits from the sale of such products after the rule becomes effective.

Moreover, it is unlikely that any industry participants will be left with substantial inventories of nonconforming products. Current smokers are likely to buy up any available inventories of such products prior to the effective date of the rule. Thus, permitting industry participants at any level to sell off existing nonconforming inventories is not only contrary to the policies that underlie adoption of the rule, but is also wholly unnecessary to address any legitimate interest that a seller of tobacco products might have.

D. FDA Should Require a Standard Method of Product Testing to Analyze Nicotine Levels. (***ANPRM, Section D, Question 6***)

FDA asks whether, if it issues a product standard, it should require a standard method of product testing to analyze the nicotine levels in products subject to the standard. Adoption of a standard method of product testing would be helpful to ensure that all products are subject to the same standard and that the standard is actually being adhered to. FDA correctly observes that, "it is critical that the results from the test method used demonstrate a high level of specificity, accuracy, and precision in measuring a range of nicotine levels across a wide variety of tobacco blends and methods."[85] In addition, FDA should require manufacturers to sample their products in a consistent manner to ensure that products do not contain excess levels of nicotine and to test each manufactured batch to ensure compliance.

[85] 83 Fed. Reg. at 11820.

V. Possible Countervailing Effects

A. The Product Standard Should Prohibit the Sale or Distribution of Liquid Nicotine or Any Other Tobacco Product Designed to Supplement the Nicotine Content of Combusted Tobacco Products. (*ANPRM Section F, Question 2*)

FDA should assess the extent to which it would be feasible for smokers to supplement the nicotine content of combusted tobacco products through the use of liquid nicotine or another tobacco product. If such supplementation is feasible in a substantial number of cases, FDA should include in the rule a prohibition on the sale or distribution of liquid nicotine or any other tobacco product designed to supplement the nicotine content of combusted tobacco products.

B. Illicit Trade (*ANPRM Section F, Questions 3, 6, 7, 9*)

These comments incorporate by reference the Comments filed by the undersigned organizations in Docket No. FDA-2018-N-0529, "Draft Concept Paper: Illicit Trade in Tobacco Products After Implementation of a Food and Drug Administration Product Standard," 83 Fed. Reg. 11754 (March 16, 2018).

VI. Other Considerations

A. The Potential Consumer Surplus or Utility Loss from the Removal of Nicotine from Combusted Tobacco Products is Minimal in Light of the Availability of Other Sources of Nicotine and the Continued Availability of Tobacco Products. (*ANPRM, Section G, Question 2*)

The measurement of consumer surplus or utility loss in the context of the regulation of an addictive product, such as cigarettes, has been the subject of considerable debate. In 2014, a group of distinguished health economists presented to the U.S. Department of Health and Human Services and subsequently published a proposed formulation for the measurement of such consumer surplus or utility loss in this context.[86] After citing the fact that the large majority of smokers started smoking before the legal purchase age, regret the fact that they had started smoking and become addicted, and wished they could quit, the paper concluded:

> "Indeed, the data strongly suggest that many smokers do not find smoking pleasurable, and that they derive little consumer surplus from smoking. Instead, most are struggling with or avoiding the withdrawal they would experience if they were able to stop smoking

[86] Chaloupka FJ, et al., "An Evaluation of the FDA's Analysis of the Costs and Benefits of the Graphid Warning Label Regulation," *Tobacco Control*, 24:112-119, 2015.

and break an addiction they regret having ever started, facing psychological costs from being addicted and lacking the self-control to quit."[87]

Accordingly, the paper recommended that, "nearly all of the lost pleasure from tobacco use, as represented by conventionally measured consumer surplus, should not be included as a cost in FDA analysis of the economic impact of its tobacco regulations."[88] To the extent that measurement of consumer surplus or utility loss is required in the evaluation of regulations involving tobacco products, the undersigned organizations urge FDA to adopt the methods described in that paper.

In this case, there are further reasons why consumer surplus or utility loss, to the extent the concepts are relevant at all, would be minimal. If it is true that smokers smoke in order to obtain nicotine (an underlying premise of a nicotine products standard), to the extent that nicotine will remain available to them in other forms, either through appropriately regulated e-cigarettes, NRT products, or otherwise, means that the "pleasure" of receiving nicotine is not being denied to them. To the extent that these product satisfy the need for nicotine, there is no "lost pleasure." Moreover, to the extent that smokers can satisfy the need for nicotine at a far lower cost to their health indicates that individual smokers will realize a large net economic gain.

Moreover, cigarettes and other combusted tobacco products will remain available for sale. To the extent that smokers derive pleasure from smoking apart from satisfying their need for nicotine, they will continue to be able to purchase cigarettes and other combusted products. Having access to both nicotine and combusted tobacco products, it is questionable whether smokers will experience any loss of consumer surplus, even assuming that such surplus is generated by smoking.

B. FDA Should Consider Externalities, Such as the Reduction in Secondhand Smoke, in Evaluating the Consequences of the Rule (***ANPRM Section G, Question 6***)

If, as expected, a product standard reducing the level of nicotine in cigarettes and other combusted products substantially reduces the number of cigarettes and other combusted tobacco products smoked, there will be a corresponding reduction in environmental tobacco smoke and in the death and disease resulting from non-smokers' exposure to such smoke. FDA estimates that from 2005 to 2009, an estimated 7,330 lung cancer and 33,950 heart disease deaths were attributable to secondhand smoke and that secondhand tobacco smoke causes premature death and disease in children and adults who do not smoke.[89] It is apparent that a reduction in environmental tobacco smoke would reduce the burden of death and disease for non-smokers and provide a substantial public health benefit. Any analysis of the effects of such a rule should

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87 *Id.*

88 *Id.*

89 83 Fed. Reg. at 11825.

consider the benefits to non-smokers that would result through a reduction in death and disease attributable to environmental tobacco smoke.

C. Post-market Surveillance is Critical

Critical to the success of a nicotine reduction policy is a rigorous and comprehensive post-market surveillance and product-testing program to monitor for any unintended tobacco use patterns and to identify any changes in product design that may limit the effectiveness of reduced nicotine content.

Respectfully submitted,

Action on Smoking and Health
American Academy of Family Physicians
American Academy of Oral and Maxillofacial Pathology
American Association for Dental Research
American Association for Respiratory Care
American Cancer Society Cancer Action Network
American College of Cardiology
American College of Physicians
American College of Preventive Medicine
American Heart Association
American Lung Association
American Medical Association
American Medical Student Association
American Psychological Association
American Public Health Association
American School Health Association
American Society of Addiction Medicine
American Society of Clinical Oncology
Americans for Nonsmokers' Rights
Association of State and Territorial Health Officials
Big Cities Health Coalition
Campaign for Tobacco-Free Kids
Community Anti-Drug Coalitions of America
Counter Tools
Eta Sigma Gamma - National Health Education Honorary
Mesothelioma Applied Research Foundation
National Association of County and City Health Officials
National Hispanic Medical Association
National Network of Public Health Institutes
Oncology Nursing Society
Oral Health America
Prevention Institute
Public Health Law Center | Tobacco Control Legal Consortium
Public Health Solutions
Society for Cardiovascular Angiography and Interventions
Society for Public Health Education
Students Against Destructive Decisions
The Society for State Leaders of Health and Physical Education
Trust for America's Health
Truth Initiative

AMA
AMERICAN MEDICAL ASSOCIATION

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July 16, 2018

Scott Gottlieb, MD
Commissioner
U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Re: Docket No. FDA-2017-N-6189; APRM; Tobacco Product Standard for Nicotine Level of Certain Tobacco Products

Dear Commissioner Gottlieb:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Food and Drug Administration's (FDA) advance notice of proposed rulemaking (APRM) titled, "Tobacco Product Standard for Nicotine Level of Combusted Cigarettes," as referenced above.

Tobacco use is the leading preventable cause of death in the United States. The AMA applauds the FDA's decision to gather information regarding the development and implementation of a regulation that would reduce nicotine levels in cigarettes to non-addictive levels. This step toward reducing the addictive power of cigarettes is in line with AMA policy, which has for years encouraged the FDA and other appropriate agencies to study how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and other additives that enhance addictiveness.

The AMA has joined other medical and public health organizations in submitting comments in this docket (see letter submitted by the Campaign for Tobacco-Free Kids, American Cancer Society Cancer Action Network, American Heart Association, and American Lung Association). These comments outline the public health impact of reducing nicotine in combustible tobacco products, application of the nicotine standard to other combustible tobacco products, implementation considerations, technical achievability, possible countervailing effects, as well as other considerations. In addition to those comments, the AMA believes the scope of the APRM should be expanded to cover all tobacco products.

The AMA calls on the FDA to create a non-addictive nicotine level standard for all tobacco products, not just cigarettes. This includes smokeless tobacco, electronic nicotine delivery systems (ENDS), "heat not burn products," and any other tobacco products containing nicotine for recreational use. Cigarettes are not the only addictive form of tobacco, and applying this standard across all tobacco products is essential to combating the leading cause of preventable death. If FDA reduces nicotine content in combustible tobacco products without already having a regulatory strategy in place that appropriately addresses ENDS, it will miss a critical opportunity to reduce overall nicotine addiction and use of tobacco products. Comprehensive and specific regulations are necessary to prevent new products that may circumvent the nicotine level requirement.

The AMA acknowledges that all tobacco products (including, but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health. Furthermore, the use of ENDS is not harmless and increases youth risk of using combustible tobacco cigarettes. We recognize that the use of products containing nicotine in any form among youth, including ENDS, is unsafe and can cause addiction.

In summary, we greatly appreciate the FDA's effort to develop a product standard for a maximum nicotine level for cigarettes, and urge the FDA to extend this rulemaking to all tobacco products, including noncombustible products like ENDS. We thank you for your consideration of these comments, and look forward to a final rule that prioritizes the health of the public. If we may provide further assistance, please contact Margaret Garikes, Vice President, Federal Affairs at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-19)
Vector-borne Diseases
(Resolution 430-A-18, first and second Resolves)
(Reference Committee D)

EXECUTIVE SUMMARY

Background. This report responds to Resolution 430-A-18, "Vector-borne Diseases" introduced by the American Academy of Dermatology along with 24 state and national medical specialty societies, and referred by the House of Delegates. This resolution asked the AMA to study the emerging epidemic of vector-borne diseases.

Methods. English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2014 to January 2019 using the search terms "vector-borne disease," "tick-borne disease," "mosquito-borne disease," "Lyme disease," "post treatment Lyme disease," "chronic Lyme disease," "West Nile virus," and "Zika virus." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal, state, and local agencies and applicable national public health, entomology, and mosquito control organizations also were reviewed for relevant information.

Results. In the United States, nearly 650,000 cases of vector-borne diseases (VBD) were reported from 2004–2016. Reported cases of tick-borne disease (TBD) doubled in the 13-year analysis period. TBDs account for more than 75 percent of VBDs reports throughout the continental United States and Lyme disease accounts for the majority (82 percent) of cumulative reported TBD. West Nile Virus was the most commonly transmitted mosquito-borne disease (MBD) in the continental United States from 2004-2016. Epidemics of dengue, chikungunya, and Zika viruses were mostly confined to the U.S. territories. This report focuses broadly on the prevention of VBDs, followed by specific discussions on the diagnosis and treatment of the most prevalent TBDs and MBDs – Lyme disease and West Nile Virus (WNV), respectively.

Conclusion. VBDs are a growing health threat in the United States and one that climate change is expected to exacerbate. The most common VBDs in the United States are Lyme disease, Rocky Mountain spotted fever, WNV, dengue, and Zika virus disease. From a public health perspective, to effectively reduce transmission and respond to VBD outbreaks, improvements in surveillance, reporting, and adequate vector control will be necessary, but as a nation we currently have limited capacity to respond to vector-borne diseases. With approximately 80 percent of our nation's vector control organizations lacking critical prevention and control capacities, sustained investment in improving these capabilities is needed as are investments in our public health infrastructure and workforce.

For health professionals to adequately care for patients infected with VBDs, clinical research is needed to improve their diagnosis and treatment. Educating health professionals and the public about existing and emerging VBDs will be critical to addressing both prevention and treatment efforts. Lyme disease should be an area of focus in these efforts since it is the most common VBD in the United States. Furthermore, with there being only one nationally notifiable VBD with an FDA approved vaccine available, vaccine development for VBDs should be prioritized. To accomplish these goals, additional and sustained funding for VBDs will be necessary.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-19

Subject: Vector-borne Diseases
(Resolution 430-A-18, first and second Resolves)

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, MPH, Chair)

The first and second resolves of Resolution 430-A-18, introduced by the American Academy of Dermatology along with 24 state and national medical specialty societies, and referred by the House of Delegates asks:

> That our American Medical Association (AMA) study the emerging epidemic of vector-borne diseases including an analysis of currently available testing and treatment standards and their effectiveness, and issue a white paper on vector-borne diseases (VBD) for the purpose of increasing awareness of the epidemic of vector-borne diseases.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2014 to January 2019 using the search terms "vector-borne disease," "tick-borne disease," "mosquito-borne disease," "Lyme disease," "post treatment Lyme disease," "chronic Lyme disease," "West Nile virus," and "Zika virus." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal, state, and local agencies and applicable national public health, entomology, and mosquito control organizations also were reviewed for relevant information.

CURRENT AMA POLICY

Existing AMA policy on VBD urges the AMA to support educating the medical community on the potential adverse public health effects, including VBDs, of global climate change. Policy also calls on the AMA to advocate for local, state and national research, education, reporting, and tracking on VBDs. Our policy on zoonotic diseases asks the AMA to collaborate with the American Veterinary Medical Association and other stakeholders to take the lead in establishing a robust, coordinated, and effective global surveillance system of zoonotic diseases in humans and syndromic outbreaks in animals. In terms of policy on specific VBDs, existing policy addresses Zika virus by calling for funding and the development of strategies to limit the spread and impact of the virus as well as approaches to minimize the transmission to potentially pregnant women.

BACKGROUND

Vectors are blood-feeding insects and ticks capable of transmitting pathogens between hosts. Wide varieties of pathogens have evolved to exploit vector transmission, including some viruses, bacteria, rickettsia, protozoa, and helminths.[1] Mosquitos, ticks, and fleas are the most common

vectors in the United States. Diseases from mosquito and tick bites occur in every U.S. state and territory.[2] The growing incidence of Lyme disease and recent outbreaks of Zika virus and chikungunya points to the need for comprehensive VBD programs and for increased awareness of these diseases by clinicians and patients. Climate change creates additional concern about the spread of VBDs as changing temperatures may expand the geographic range of disease-carrying insects.

EPIDEMIOLOGY

VBDs are a major cause of death and illness worldwide. Every year, VBDs such as malaria, dengue, and yellow fever, account for more than 700,000 deaths globally.[3] The burden of these diseases is highest in tropical and subtropical areas and they disproportionately affect poor populations.[3] In the United States, 16 VBDs are reportable to state and territorial health departments and the National Notifiable Disease Surveillance System. The most common VBDs in the United States are Lyme disease, Rocky Mountain spotted fever, West Nile virus (WNV), dengue, and Zika virus disease.[2] Malaria and yellow fever are no longer transmitted in the United States, but are monitored because they have potential to re-emerge. As a group, VBDs in the United States are notable for their wide distribution and resistance to control.[1] Yellow fever is the only nationally notifiable VBD for which there is an FDA-approved vaccine available.[2]

In the United States, nearly 650,000 cases of VBD were reported from 2004–2016.[1] Reported cases of tick-borne disease (TBD) doubled in the 13-year analysis period.[1] TBDs account for more than 75 percent of VBDs reports throughout the continental United States and Lyme disease accounts for the majority (82 percent) of cumulative reported TBD.[1] In addition to Lyme disease, other common illnesses caused by ticks are Rocky Mountain spotted fever, babesiosis, ehrlichiosis, anaplasmosis, tularemia, Colorado tick fever, tick-borne relapsing fever, and Powassan disease. While TBDs are prevalent throughout the country, they are predominately found along the northeastern coast, in the upper Midwest, and along the Pacific coast.

WNV was the most commonly transmitted mosquito-borne disease (MBD) in the continental United States from 2004-2016, with the largest outbreak occurring in 2012.[1] Epidemics of dengue, chikungunya, and Zika viruses were mostly confined to the U.S. territories. Travelers infected in the territories and Latin America accounted for more than 90 percent of the dengue, chikungunya, and Zika virus cases identified in the continental United States.[1] Limited local transmission of dengue occurred in Florida, Hawaii, and Texas, and of chikungunya and Zika viruses in Texas and Florida.[1] Malaria was diagnosed in approximately 1,500 travelers yearly, but no local transmission was documented from 2004–2016.[1]

Given the broad range of VBDs, CSAPH decided to focus the scope of this report broadly on the prevention of VBDs, followed by specific discussions on the most prevalent TBDs and MBDs – Lyme disease and WNV, respectively.

PREVENTION OF VBDs

Vector Control Programs

Vector control programs vary by jurisdiction. These responsibilities may fall to the local health department, mosquito control district, or a variety of other local agencies (public works, streets and sanitation, parks and recreation, or other environmental health services).[4] The result is differing capabilities across the country. The Centers for Disease Control and Prevention (CDC) has outlined core competencies for vector control programs. The competencies include: (1) routine mosquito

surveillance through standardized trapping and species identification; (2) treatment decisions using surveillance data; (3) larviciding, adulticiding, or both; (4) routine vector control activities (i.e., chemical, biological, source reduction, or environmental management); and (5) pesticide resistance testing. There are five supplemental competencies, these include (1) licensed pesticide application; (2) vector control other than chemical control (i.e., biological, source reduction, or water management); (3) community outreach and education campaigns regarding mosquito-borne diseases, how they spread, and how to prevent infection; (4) regular communication with local health departments regarding surveillance and epidemiology; and (5) outreach (i.e., communication and/or cooperation).

A survey of vector control organizations in the United States (n=1,083) found that based on the CDC competencies, 34 percent of mosquito control districts perform all core competencies versus 6 percent and 7 percent of local health departments and other organizations, respectively.[4] Of the competencies that vector control programs ranked as "needs improvement," nearly all of them (98 percent) lacked the capability or capacity to perform pesticide resistance testing.[4] More than half also lack the ability to perform routine surveillance and species identification.[4]

Another approach to vector control that is being considered to prevent VBDs is the use of novel technologies. One example is the use of genetically engineered mosquitos to prevent the spread of Zika virus. Specifically, the male *Aedes aegypti* mosquitos are genetically engineered to express a gene that encodes a conditional or repressible lethality trait and a red fluorescent marker protein to aid in the identification of these mosquitoes.[26] If a female *Aedes* mosquito mates with a sterile male then it will have no offspring, reducing the next generation's population.[26] Repeated release of insects can reduce the insect population to very low levels. The Environmental Protection Agency (EPA) has been considering a pilot to determine the efficacy of these genetically engineered mosquitos in the Florida Keys.

Personal Protection from Vectors

For mosquitos, personal protection from vectors involves using an EPA-registered insect repellent with one of the following active ingredients: DEET, Picaridin, IR3535, oil of lemon eucalyptus or para-methane-diol, or 2-undecanone.[5] Individuals should also treat items such as boots, pants, socks, and tents with permethrin or purchase permethrin-treated clothing and gear.[5] Homes should also be mosquito-proofed by using screens on windows and doors and repairing holes in screens to keep mosquitos outside.[5] It is also recommended to use air conditioning when available and to eliminate standing water outside your home to keep mosquitos from laying eggs.[5] It is important to remember that vector-borne diseases affect the poor disproportionately. Overall, changes in living conditions in the United States have resulted in decreased local transmission of MBD such as yellow fever, malaria, and dengue.[22]

For ticks, the use of EPA-registered insect repellents and permethrin treating clothing and gear is also recommended. Individuals are encouraged to avoid contact with ticks by avoiding wooded and brushy areas with high grass and leaf litter, and walk in the center of trails.[6] Once indoors, individuals should check their clothing and body for ticks after being outdoors. Showering within two hours of coming indoors has been shown to reduce the risk of Lyme disease as it may help wash off unattached ticks.[6] If a tick is attached to the skin the key is to remove it as soon as possible by using fine-tipped tweezers to grasp the tick as close to the skin's surface as possible and pull upward.[7] Testing of ticks for evidence of infection is not recommended.[7]

DISCUSSION

Once an individual has been bit by an infected vector and/or suspects they may have been exposed to a VBDs, health care professionals may be consulted for diagnosis and treatment. The CDC has developed a reference manual for health care providers on tick-borne diseases in the United States that provides an overview of ticks and the infections they transmit.[6] The manual also provides information on incubation periods, signs and symptoms, diagnosis, and treatment.[6] A similar manual for MBDs and other VBDs does not currently exist.

Lyme Disease

Lyme disease, the leading VBD in the United States, is caused by *Borrelia burgdorferi*, which is transmitted by the bite of the tick species *Ixodes scapularis* and *Ixodes pacificus*. In 2017, a total of 42,743 confirmed and probable cases of Lyme disease were reported to CDC, nearly 9 percent more than the previous year.[8] The geographic distribution of Lyme disease appears to be expanding. The number of counties with an incidence of ≥10 confirmed cases per 100,000 persons increased from 324 in 2008 to 454 in 2017.[8]

Signs and Symptoms. The majority (70 to 80 percent) of patients with Lyme disease develop the characteristic skin lesion, erythema migrans (EM).[12] The rash begins at the site of the tick bite and expands. It sometimes has a target or "bull's-eye" appearance. Other early signs include flu like symptoms – fever, chills, headache, fatigue, muscle and joint aches, and swollen lymph nodes.[9] Longer-term symptoms include severe headaches and neck stiffness, additional EM rashes, arthritis, facial palsy, Lyme carditis, nerve pain, and inflammation of the brain and spinal cord.[9] Recurrent large-joint arthritis signals late disseminated disease (more than six months post bite).[10] Late neurologic Lyme disease signaled by peripheral neuropathy, encephalopathy, or encephalomyelitis is uncommon in the United States.[10]

Diagnosis. There are 3 stages of *B. burgdorferi* infection: early localized, early disseminated, and late disseminated.[10] Patients with an EM lesion and epidemiologic risk can receive a Lyme diagnosis without laboratory testing. However, for all other patients, laboratory testing is necessary to confirm the diagnosis.[10]

Serological assays that detect antibodies against *B.burgdorferi* are the only lab test cleared by FDA and recommended by CDC for diagnosis of Lyme disease. A two-step process is used to diagnose Lyme disease (See Figure 1.) The first required test is the Enzyme Immunoassay (EIA) or Immunofluorescence Assay (IFA). If this test yields negative results, the provider should consider an alternative diagnosis; or in cases where the patient has had symptoms for less than or equal to 30 days, the provider may treat the patient and follow up with a convalescent serum. If the first test yields positive or equivocal results, two options are available: (1) If the patient has had symptoms for less than or equal to 30 days, an IgM Western Blot is performed; and (2) if the patient has had symptoms for more than 30 days, the IgG Western Blot is performed. The IgM should not be used if the patient has been sick for more than 30 days. The sensitivity of 2-tiered testing is low (30–40 percent) during early infection while the antibody response is developing.[10] For disseminated Lyme disease, sensitivity is 70–100 percent. Specificity is high (>95 percent) during all stages of disease.[10]

Since serological tests measure a person's past or present immune response to infection, they can be negative during first several days to weeks of infection. This results in patients not being diagnosed with appropriate diseases or receiving proper treatment. Serologic tests also cannot distinguish active infection, past infection, or reinfection. In cases of reinfection, it may be helpful

to conduct acute-phase and convalescent-phase serologic analysis to detect an increase in EIA titer or an increase in the number of antibody bands that might indicate active infection.[10] When determining whether to test for Lyme disease, clinicians must consider a patient's pretest probability as false-positive results can occur when tests are performed for patients with low pretest probability.[10]

There have been recent proposals to change the recommended 2-tier algorithm for serologic testing for Lyme disease from the current standard to one in which a second-tier EIA would be used instead of a Western blot.[10,11] This approach would make the tests easier to perform, results would be available sooner, costs would be reduced, and it would eliminate the subjective element inherent in interpretation of Western blots.[11] Further research is needed.[10,11]

Treatment. Patients treated during the early stages of Lyme disease typically recover rapidly and have good outcomes. Treatment guidelines developed by the Infectious Diseases Society of America recommend that early localized disease be treated with oral antibiotics.[23] Doxycycline 100 mg orally twice daily for 10–21 days, or cefuroxime axetil 500 mg orally twice daily or amoxicillin 500 mg orally 3 times daily for 14–21 days, has been shown to be effective in resolving early Lyme disease and in preventing progression.[23] People with certain neurological or cardiac forms of illness may require intravenous treatment with antibiotics such as ceftriaxone or penicillin.[23]

While most patients diagnosed with early acute Lyme disease who are treated with appropriate courses of antimicrobial therapy become symptom free, 10–20 percent of patients continue to experience symptoms that can persist for six months or longer. Post-treatment Lyme Disease (PTLD) or "chronic Lyme disease" commonly refers to the continuation of such symptoms as fatigue, myalgia, arthralgia, memory loss, and headache after antibiotic therapy for Lyme disease. Whether chronic disease is a legitimate clinical entity has become highly controversial.[12-15,23,30] The mechanism behind this persistence in some patients is unknown, but has been suggested to be due to preexisting damage from the inflammatory response to infection, from persistent low-level infection, or to an autoimmune response.[13] Trials examining the effect of repeated antibiotic treatment in PTLS have shown no significant sustained benefit.[13,23] The Infectious Diseases Society of America is currently in the process of updating their guidelines on Lyme disease, with a project publication date of Winter 2020.

Costs. A comprehensive understanding of the full economic and societal costs of Lyme disease remains unknown. The total direct medical costs attributable to Lyme disease and PTLD are estimated to be somewhere between $712 million - $1.3 billion each year in the United States.[28]

Vaccine. LYMErix™, a noninfectious recombinant vaccine for Lyme disease, was available in the United States from 1998-2002.[21] The Food and Drug Administration approved vaccine, which reduced new infections in vaccinated adults by nearly 80 percent, was voluntarily withdrawn from the market because of media coverage, fears of vaccine side-effects, and declining sales.[27]

West Nile Virus

WNV is the leading cause of mosquito-borne disease in the continental United States. In 2018, 49 states and the District of Columbia reported WNV infections in people, birds, or mosquitoes. 2,544 cases of WNV in people were reported to CDC last year.[25] Of these, 1,594 (63 percent) were classified as neuroinvasive disease and 950 (37 percent) were classified as non-neuroinvasive disease.[25] In 2018, 137 deaths were reported.[25]

Signs and Symptoms. Most people infected with WNV do not develop any symptoms.[16] Approximately 1 in 5 people will develop a fever as well as headache, body aches, joint pains, vomiting, diarrhea, or rash.[16] About 1 in 150 people who are infected develop a severe illness affecting the central nervous system such as encephalitis or meningitis.[16] Symptoms of severe illness include high fever, headache, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, vision loss, numbness and paralysis.[16]

Diagnosis. Diagnosis of WNV is generally accomplished through laboratory testing of serum or cerebrospinal fluid (CSF) to detect WNV-specific IgM antibodies, which are usually detectable three to eight days after onset of illness and persist for 30 to 90 days.[16] Positive results obtained with these assays should be confirmed by neutralizing antibody testing of acute- and convalescent-phase serum specimens at a state public health laboratory or CDC. WNV IgG antibodies generally are detected shortly after IgM antibodies and persist for many years. Therefore, the presence of IgG antibodies alone is only evidence of previous infection.[16]

Viral cultures and tests to detect viral RNA (i.e., reverse transcriptase-polymerase chain reaction can be performed on serum, CSF, and tissue specimens that are collected early in the course of illness and, if results are positive, can confirm an infection. Immunohistochemistry can detect WNV antigen in formalin-fixed tissue.[16] Negative results of these tests do not rule out WNV infection.[16]

Treatment. There is no specific treatment for WNV disease. Patients with severe meningeal symptoms may require pain control for headaches and antiemetic therapy and rehydration for associated nausea and vomiting.[16] Patients with encephalitis require close monitoring for the development of elevated intracranial pressure and seizures.[16] Patients with encephalitis or poliomyelitis should be monitored for inability to protect their airway.[16] Acute neuromuscular respiratory failure may develop rapidly and prolonged ventilatory support may be required.[16]

Costs. Data suggests the total cumulative costs of reported WNV hospitalized case-patients during 1999–2012 were $778 million, which is an average of approximately $56 million per year.[29]

Vaccines. There are no WNV vaccines licensed for use in humans.

EMERGING AND RE-EMERGING VBDs

Since 2004, the United States has seen an increasing number of new or re-emerging vector-borne pathogens.[1,20] This includes previously unknown tick-borne RNA viruses, a tick-borne relapsing fever agent, and two tick-borne spotted fever species as well as the introduction of mosquito viruses, chikungunya and Zika, introduced in Puerto Rico in 2014 and 2015, respectively.[1]

Zika virus disease

Zika virus is a Flavivirus, which is transmitted to humans primarily through the bite of an infected Aedes species mosquito (*Ae. aegypti* and *Ae. albopictus)*.[17] In 2015 and 2016, outbreaks of Zika virus occurred in the Americas, resulting in travel-associated cases in the United States, widespread transmission in the U.S. territories, and limited local transmission in Florida and Texas.[18] Zika virus infection during pregnancy has been demonstrated to cause birth defects such as microcephaly and other severe brain defects.[18] From January 15 through December 27, 2016, a total of 1,297 pregnancies with possible Zika virus infection were reported to the U.S. Zika Pregnancy Registry.[24] Birth defects were reported for 51 (5 percent) of the 972 completed

pregnancies with laboratory evidence of possible recent Zika virus infection.[24] Zika is the only arbovirus known to be transmitted sexually.

Longhorned Tick (Haemaphysalis longicornis)

Haemaphysalis longicornis is indigenous to eastern Asia and is an important vector of human and animal disease agents, including Rickettsia, Borrelia, Ehrlichia, Anaplasma, Theileria, and several important viral agents such as Heartland and Powassan viruses.[19] *Haemaphysalis longicornis* was discovered on a sheep in New Jersey in August 2017. From August 2017 through September 2018, vector and animal surveillance efforts resulted in 53 reports of *Haemaphysalis longicornis* in the United States, including 38 from animal species (23 from domestic animals, 13 from wildlife, and two from humans), and 15 from environmental sampling of grass or other vegetation.[19] Most of these reports have come from the eastern portion of United States.[19] No cases of illness in humans or other species have been reported to date.[19]

CONCLUSION

VBDs are a growing health threat in the United States and one that climate change is expected to exacerbate. The most common VBDs in the United States are Lyme disease, Rocky Mountain spotted fever, WNV, dengue, and Zika virus disease. From a public health perspective, to effectively reduce transmission and respond to VBD outbreaks, improvements in surveillance, reporting, and adequate vector control will be necessary, but as a nation we currently have limited capacity to respond to vector-borne diseases. With approximately 80 percent of our nation's vector control organizations lacking critical prevention and control capacities, sustained investment in improving these capabilities is needed as are investments in our public health infrastructure and workforce.

For health professionals to adequately care for patients infected with VBDs, clinical research is needed to improve their diagnosis and treatment. Educating health professionals and the public about existing and emerging VBDs will be critical to addressing both prevention and treatment efforts. Lyme disease should be an area of focus in these efforts since it is the most common VBD in the United States. Furthermore, with there being only one nationally notifiable VBD with an FDA approved vaccine available, vaccine development for VBDs should be prioritized. To accomplish these goals, additional and sustained funding for VBDs will be necessary.

RECOMMENDATIONS

The Council recommends that the following statements be adopted in lieu of Resolution 403-A-18, and the remainder of the report be filed.

1. That Policy H-440.820, "Vector-Borne Diseases," be amended by addition and deletion to read as follows:

   H-440.820 Vector-Borne Diseases
   Due to the increasing threat and limited capacity to respond to vector-borne diseases, ~~Our~~ our AMA supports and will advocate for ~~local, state and national research, education, reporting and tracking on vector-borne diseases~~.

   (1) Improved surveillance for vector-borne diseases to better understand the geographic distribution of infectious vectors and where people are at risk;

(2) The development and funding of comprehensive and coordinated vector-borne disease prevention and control programs at the state and local level;
(3) Investments that strengthen our nation's public health infrastructure and the public health workforce;
(4) Education and training for health care professionals and the public about the risk of vector-borne diseases and prevention efforts as well as the dissemination of available information;
(5) Research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases, including Lyme disease;
(6) Research to identify novel methods for controlling vectors and vector-borne diseases; and
(7) Increased and sustained funding to address the growing burden of vector-borne diseases in the United States. (Modify Current HOD Policy)

2. That Policy H-135.938, "Global Climate Change and Human Health" and Policy, D-440.940, "Global Tracking System of Zoonotic Diseases," be reaffirmed. (Reaffirm HOD Policy)

Less than $500.

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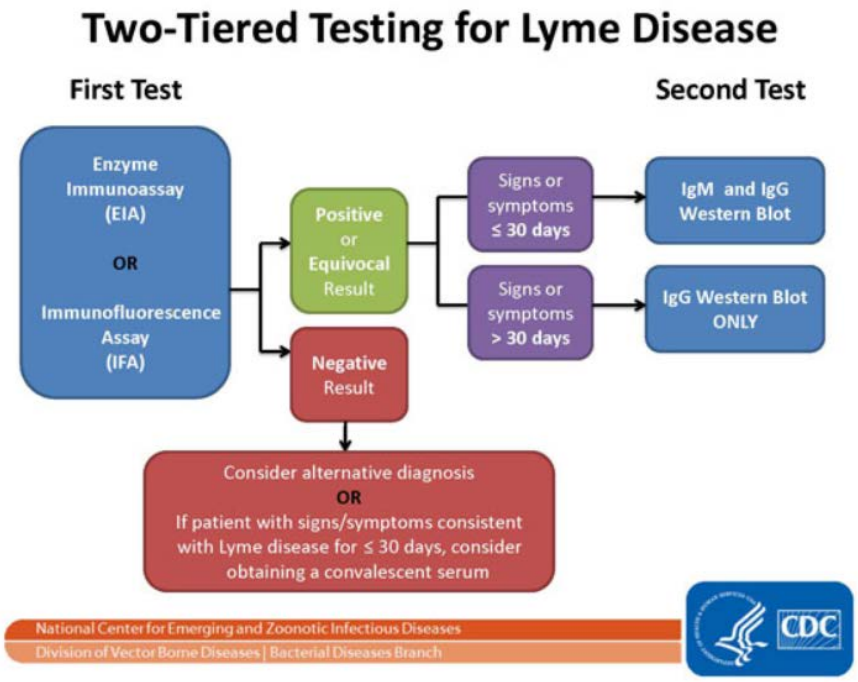
Figure 1



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-19)

Introduced by: Oregon

Subject: Support Pregnancy Intention Screenings to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Almost half (51%) of all pregnancies in the United States are unintended, which has significant physical and socio-economic consequences for women and their families, with a real cost in lives and public health; and

Whereas, Rates of unintended pregnancies disproportionally impact women of color, women in poverty, and women with less education; and

Whereas, Women with unintended pregnancies are unlikely to have taken folic acid before conceiving and are less likely to receive early prenatal care, thus increasing the risk of babies born with health challenges; and

Whereas, Women need comprehensive information, services and referrals in order to have optimal health, healthy pregnancies, and the best possible birth outcomes; and

Whereas, Providers want to use pregnancy intention screening as a routine and proactive intervention to address pregnancy intention with patients and have requested a consistent and efficient way to document care in their electronic health records; therefore be it

RESOLVED, That our American Medical Association support the use of pregnancy intention screening, such as One Key Question®, PATH, or the Centers for Disease Control and Prevention (CDC) reproductive life planning, as part of routine well care and recommend it be built in electronic health records so that providers can document intention screening and services provided based on a woman's response. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 03/04/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-19)

Introduced by: Young Physicians Section

Subject: Bullying in the Practice of Medicine

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Bullying and disrespectful behavior within the practice of medicine in the U.S. and overseas has been well demonstrated in prior studies,[2,4,6,7,9,12,16] and that perpetrators of bullying within medicine can be other physician colleagues, superior ranking colleagues in training, ancillary staff, and patients[7,9,2]; and

Whereas, "Bullying or aggressive behavior has been defined by criteria such as: intention to cause harm or distress, imbalance of power between the bully (perpetrator, aggressor) and the victim (target), and repeatability over time,"[2] and the British Medical Association defines bullying as "persistent behaviour against an individual that is intimidating, degrading, offensive or malicious and undermines the confidence and self-esteem of the recipient[10]; and

Whereas, Disrespectful behavior "encompasses a broad array of conduct, from aggressive outbursts to subtle patterns of disruptive behavior so embedded in our culture that they seem normal,"[17] and disrespectful behavior can also be considered "any behavior that influences the willingness of staff or patients to speak up or interact with an individual because he or she expects the encounter will be unpleasant or uncomfortable"[8]; and

Whereas, A survey published in 2008 found in the United States "A total of 77% of the respondents reported that they had witnessed disruptive behavior in physicians at their hospitals"[13]; and

Whereas, A 2013 survey from Institute for Safe Medication Practices exposed "healthcare's continued tolerance of and indifference to disrespectful behavior. Despite more than a decade of emphasis on safety, little improvement has been made"[8]; and

Whereas, One U.S. longitudinal survey of medical students published in 2006 demonstrated that "most medical students in the U.S. reported having been harassed or belittled during their training,"[7]; and

Whereas, Fnais et al in a 2014 meta-analysis found that "59.4% of medical trainees had experienced at least one form of harassment or discrimination during their training, with verbal harassment being the most commonly cited form of harassment"[5]; and

Whereas, "Workplace bullying is associated with stress, depression, and intention to leave"[9] and increased "absenteeism, career damage, poorer job performance, and lower productivity resulting in poorer quality of healthcare services and patient care"[2]; and

Whereas, "Victims of bullying suffer from anxiety, loss of self-control, depression, lower self-confidence, occupational job stress, job dissatisfaction, dissatisfaction with life, burnout

syndrome, musculoskeletal complaints, increased risk of cardiovascular disease, suicide attempts, and drug abuse"[2] and disrespectful behaviors "have been linked to adverse events, medical errors, compromises in patient safety, and even patient mortality"[2,8]; and

Whereas, The Joint Commission in 2008 issued an alert "warning that offensive and hostile behavior among healthcare professionals not only makes for an unpleasant working environment but can also pose a considerable threat to patient safety"[12]; and

Whereas, Creswall et al describe how British medical schools are integrating curricula to teach students how to differentiate undermining and destructive bullying behavior from constructive and supportive firm supervision, and how take action against bullying[3] and positive teaching methods have been recommended within medical education,[12,16] and formal procedures to safely, accurately, and freely report bullying are needed in order to protect bullying victims and address the issue[2,9]; therefore be it

RESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/04/19

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RELEVANT AMA POLICY

Teacher-Learner Relationship In Medical Education H-295.955
The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.
CODE OF BEHAVIOR
The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.
A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.
In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.
Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.
On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.
While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.
Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.
Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.
Citation: (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99; Modified: BOT Rep. 11, A-07; Reaffirmed: CME Rep. 9, A-13

Violence and Abuse Prevention in the Health Care Workplace H-515.966
Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.
Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16

Reduction of Online Bullying H-515.959
Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.
Citation: Res. 401, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-19)

Introduced by: Young Physicians Section

Subject: White House Initiative on Asian Americans and Pacific Islanders

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The Asian American and Pacific Islander (AAPI) community is the fastest-growing racial group in the country, growing from 46% from 2000-2010, and projected to double to over 47 million by 2060[1]; and

Whereas, There are approximately 18.9 million AAPIs and Native Hawaiians residing in the U.S., representing over 30 countries and ethnic groups that speak over 100 different languages and dialects[1]; and

Whereas, Some AAPI subgroups have staggering educational needs and health disparities that are often overlooked or masked by aggregated data; and

Whereas, According to the 2010 U.S. Census Bureau, 34% of Laotians, 38.5% of Cambodians, and 39.6% of Hmong adults do not have a high school diploma; and

Whereas, The 2006-2008 American Community Survey showed that 65.8% of Cambodian, 66.5% of Laotian, 63.2% of Hmong, and 51.1% of Vietnamese Americans have not attended college[2] and only 18.2% of Native Hawaiians have a bachelor's degree[3]; and

Whereas, There are differences in health outcomes among AAPIs when compared to other U.S. racial and ethnic groups, including:

(1) Vietnamese women experience the highest incidence rate of invasive cervical cancer; however, cancer screening rates are dramatically lower among Vietnamese American women compared to women in other ethnic and racial subgroups, with one study reporting that 1 in 3 Vietnamese-American women had never had a Papanicolaou (Pap) smear.[4]
(2) Native Hawaiians/Pacific Islanders are 2.4 times more likely to be diagnosed with diabetes, compared to non-Hispanic whites.[5]
(3) Native Hawaiians/Pacific Islanders were 3 times more likely to be obese than the overall Asian American population in 2015.[6]
(4) South Asians in the U.S. have higher hospitalization and mortality rates from atherosclerotic cardiovascular disease compared with other racial/ethnic minority groups, including a 2-fold higher prevalence of Type 2 Diabetes and a higher mortality from ischemic heart disease compared with non-Hispanic whites[8]; and

Whereas, President Bill Clinton signed Executive Order 13125 to establish the first White House Initiative on Asian Americans and Pacific Islanders “in order to improve the quality of life of Asian Americans and Pacific islanders through increased participation in federal programs where they may be underserved (e.g., health, human services, education, housing, labor, transportation and economic and community development)”[13]; and

Whereas, President George W. Bush signed Executive Order 13216 to renew the Initiative and changed the title to "Increasing Opportunity and Improving Quality of Life of Asian Americans and Pacific Islanders," and moved the Initiative from the U.S. Department of Health and Human Services to the U.S. Department of Commerce to focus on economic development[1]; and

Whereas, President Barack Obama signed Executive Order 13515, re-establishing the Initiative and moving the Initiative from the Department of Commerce to the Department of Education[1, 14]; and

Whereas, President Donald Trump issued Executive Order 13811 to re-establish the President's Advisory Commission on AAPIs[15]; and

Whereas, According to the "Healthcare and Housing" section of the website on the White House Initiative on Asian Americans and Pacific Islanders[16]:

(1) 21.4% of Pacific Islanders have low or very low food security, compared to 8.9% of the general population; and
(2) One in 12 AAPIs are living with chronic hepatitis B, making up 50% of Americans with chronic hepatitis B; and
(3) The tuberculosis rate for Native Hawaiians and Pacific Islanders is 18.2 per 100,000, compared with 0.6 per 100,000 in non-Hispanic Whites; and

Whereas, Previous iterations of the White House Initiative Asian Americans and Pacific Islanders have worked extensively on data disaggregation and published best practices on providing disaggregated AAPI data from federal surveys, including the needs to:

(1) Conduct outreach activities with AAPI community organizations, advocates, and respected leaders;
(2) Oversample the AAPI population to ensure adequate representation; and
(3) Develop language assistance programs to account for limited English proficiency; and

Whereas, Our AMA has policy that "urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders" but does not have any specific policy regarding disaggregation of AAPI data by subgroups; and

Whereas, President Obama stated in his executive order on the AAPI Initiative: "Some Asian American and Pacific Islanders, particularly new Americans and refugees, still face language barriers…And then there are the disparities that we don't even know about because our data collection methods still aren't up to par. Too often, Asian American and Pacific Islanders are all lumped into one category, so we don't have accurate numbers reflecting the challenges of each individual community. Smaller communities in particular can get lost, their needs and concerns buried in a spreadsheet[17]; therefore be it

RESOLVED, That our American Medical Association advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data (Directive to Take Action); and be it further

RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine (Directive to Take Action); and be it further

RESOLVED, That our AMA report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/04/19

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16. White House Initiative on Asian Americans and Pacific Islanders. Available at https://sites.ed.gov/aapi/healthcare-and-housing/.
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RELEVANT AMA POLICY

Health Initiatives on Asian-Americans and Pacific Islanders H-350.966

Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders.
Citation: (Res. 404, A-00; Reaffirmed: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, American Academy of Dermatology, Society for Investigative Dermatology, American Society of Dermatopathology

Subject: Shade Structures in Public and Private Planning and Zoning Matters

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Malignant melanoma is now the fifth most common cancer in the United States, and its incidence has increased 33-fold since 1935, with sun exposure being the principle cause;[1,2,3,4] and

Whereas, The Surgeon General's "Call to Action to Prevent Skin Cancer" of 2014[5] concisely outlined the magnitude of the public health problem which skin cancer represents in this country, and recommended multiple strategies to decrease the risk of this preventable cancer, including special attention to the provision of shade structures in the planning of public and private spaces; and

Whereas, Shade structures are often treated as accessory buildings in planning and zoning matters, and this can result in the denial of reasonable shade protection in public and private spaces; therefore be it

RESOLVED, That our American Medical Association support sun shade structures (such as awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of sun protection as a public health measure. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/12/19

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3. Skin Cancer Foundation Journal Vol 29; 65-67
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5. *The Surgeon Generals Call to Action to Prevent Skin Cancer* 2014

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-19)

Introduced by: California

Subject: Gun Violence Prevention: Safety Features

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The ongoing tragedy of gun violence in the United States has been labeled a public health crisis by the AMA and others, with huge attendant financial costs to hospitals, health systems, insurers, and many others; and

Whereas, In 2016, more than 38,000 deaths were caused by firearms; and

Whereas, The economic burden of firearm death and injury is substantial, reaching approximately $229 billion in aggregate costs and representing about 1.4 percent of U.S. gross domestic product for costs associated with health care, criminal justice, loss of income, pain, suffering and loss of quality of life; and

Whereas, Some companies are working on gun safety technologies, such as magazine discharge mechanisms, and indicators that show a gun is loaded, to reduce the danger of firearms for gun owners and their families; there is also federal legislation to require all gun-makers in five years to retrofit guns with personalization technology that would only allow the owners to shoot the guns; and

Whereas, It has been well established that the gun industry and gun advocacy groups, such as the National Rifle Association, have successfully fought virtually any proposed safety features, regulatory proposals, or epidemiological research that could lessen gun-related accidents and violence; and

Whereas, The federal government holds manufacturers to strict safety standards regarding almost every consumer product built within U.S. borders, such as toys, cars and medications – which allows consumers to reasonably assume that the products we buy and use every day are safe. But with guns, there are no federal regulations regarding the safety standards of firearms produced within the U.S. – an oversight in consumer protection that often proves deadly; and

Whereas, From 2005-2010, 3,800 people were killed and more than 95,000 injured (42,000 under the age of 25) from unintended shootings that could have been prevented through better gun safety standards and safety testing for mechanical defects; and

Whereas, Public health organizations have produced many evidence-based materials and recommendations to lessen gun-related harms, but many experts believe that, as with the tobacco industry in the past, the gun industry escapes true responsibility and liability for the harms and costs caused by their products; therefore be it

RESOLVED, That our American Medical Association advocate for gun safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these gun safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured guns. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/29/19

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

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.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

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.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: , I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-19)

Introduced by: California

Subject: Reduction in Consumption of Processed Meats

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Processed meats include (but are not limited to) bacon, sausages, hot dogs, salami, corned beef, beef jerky, ham, canned meat, ground beef processed with ammonia and other cured meat; and

Whereas, The International Agency for Research on Cancer (IARC) part of the World Health Organization (WHO) has classified processed meats as a Group 1 carcinogen after reviewing over 800 research studies; and

Whereas, Processed meats are associated with diabetes, hypertension, chronic obstructive pulmonary disease (COPD) and coronary artery disease 2; therefore be it

RESOLVED, That our American Medical Association support reduction of processed meat consumption, especially for patients diagnosed or at risk for coronary artery disease, type 2 diabetes and colorectal cancer (New HOD Policy); and be it further

RESOLVED, That our AMA support initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition (New HOD Policy); and be it further

RESOLVED, That our AMA support public awareness of the risks of processed meat consumption, including research that better defines the health risks imposed by different methods of meat processing (New HOD Policy); and be it further

RESOLVED, That our AMA support educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-19)

Introduced by: California

Subject: Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Motor vehicle accidents are responsible for significant morbidity and mortality in the U.S. In 2015, there were 3,176 deaths in California alone; and

Whereas, Over 90% of all motor vehicle accidents are primarily attributable to driver error, and over 40% of fatal accidents involve substance use, fatigue, or a distracted driver; and

Whereas, Existing partially automated systems, such as autonomous emergency braking, demonstrably reduce the incidence of collision-related injury; and

Whereas, Fully autonomous vehicles have the potential to prevent a significant proportion of motor vehicle accidents by substantially reducing driver error, which could in turn reduce injury, death, healthcare resource utilization, and healthcare spending; and

Whereas, The U.S. National Highway Traffic Safety Administration has voiced optimism for the potential of autonomous vehicles to play a significant role in improving transportation safety, and has published a guidance for the automobile industry accordingly; and

Whereas, Age-related loss in the ability to operate motor vehicles increases individuals' risk for depression; therefore be it

RESOLVED, That our American Medical Association monitor the development of autonomous vehicles, with particular focus on the technology's impact on motor vehicle related injury and death (Directive to Take Action); and be it further

RESOLVED, That our AMA promote driver, pedestrian, and general street and traffic safety as key priorities in the development of autonomous vehicles. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-19)

Introduced by: Illinois

Subject: Banning Edible Cannabis Products

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, In general, children have more severe symptoms from cannabis toxicity (with leukocytosis and elevated lactic acid levels); and

Whereas, The pharmacology of edible cannabis makes this a poorly viable medicinal agent due to its low oral bioavailability (under 25%) and slow peak absorption (almost 3 hours); and

Whereas, Toddlers are increasingly accessing edible cannabis products with subsequent severe neurotoxicity and cardiotoxicity; and

Whereas, No antidote exists for cannabis toxicity, and activated charcoal is apparently not effective; and

Whereas, Unintentional cannabis ingestion by adults can lead to unintended medical and forensic consequences (such as a positive drug test leading to job termination); and

Whereas, There is no US Food and Drug Administration oversight on medicinal edible cannabis products; and

Whereas, Colorado studies along with National Poison Data System encounters due to unintentional pediatric cannabis exposures have increased substantially in legalized cannabis states; and

Whereas, Some states and localities have restricted or outlawed the sale of flavored tobacco products because of the concern that they increase pediatric initiation, i.e., first use of the product; and

Whereas, There is much more risk of initiation with candy marijuana than with flavored tobacco products; and

Whereas, Consumers often do not understand toxic hazards of edible cannabis and may consume a greater than intended amount; therefore be it

RESOLVED, That our American Medical Association adopt policy supporting a total ban on recreational edible cannabis products (New HOD Policy); and be it further

RESOLVED, That our AMA support or cause to be introduced legislation to ban all recreational edible cannabis products. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-19)

Introduced by: New York

Subject: Addressing the Vaping Crisis

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Vaping / E-cigarettes may be useful in helping smokers stop smoking; and

Whereas, Vaping has no other healthful purposes and these devices will, on rare occasion, explode; and

Whereas, Vaping is highly addictive, and is marketed to children, and often leads to smoking; therefore be it

RESOLVED, That our American Medical Association advocate to the Food and Drug Administration that vaping devices should be available only by prescription for smokers who are trying to quit smoking. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-19)

Introduced by: New York

Subject: Reducing Health Disparities Through Education

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The favorable direct impact of education on health outcomes has been well documented for years, with improved outcomes at each additional level obtained from high school graduation to post graduate degrees; and

Whereas, The high school graduation rate in the lower socioeconomic group is <30% compared to an overall U.S. graduation rate of >80%; and

Whereas, The cost of a college degree is constantly rising with the average cost of a 4-year degree in the U.S. is presently on average $28,000 to $34,000. The former for public college, the latter for private colleges; and

Whereas, There are many environmental factors that impact health outcomes (e.g. a safe out door space to exercise, the concentration of fast food restaurants, the availability of fresh, affordable fruits and vegetables) in poor neighborhoods etc., in spite of the environmental circumstances educational attainment helps to mitigate the negative impact of these circumstances; and

Whereas, Personal behaviors informed by education leads to a decrease in unhealthy behaviors (e.g. smoking); and

Whereas, Educational attainment leads to improved rates of secondary prevention (e.g. age appropriate screenings); therefore be it

RESOLVED, That our American Medical Association work with the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education (Directive to Take Action); and be it further

RESOLVED, That our AMA work with HHS and DOE to establish a meaningful health curriculum (including nutrition) for grades kindergarten through 12 which is required for high school graduation (Directive to Take Action); and be it further

RESOLVED, That our AMA work nationally toward the same goals and strategies to reduce health disparities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-19)

Introduced by: New York

Subject: AMA to Analyze Benefits / Harms of Legalization of Marijuana

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Rates of marijuana use among the US population has increased in the past decade; and

Whereas, Marijuana is a complex botanical with many different compounds with potential pharmacological activity; and

Whereas, There is some high quality evidence for efficacy of some marijuana compounds for treatment of disease or alleviation of symptoms; and

Whereas, There are structural impediments to high quality research due to marijuana being classified as a Schedule I substance by the Food and Drug Administration; and

Whereas, There is accumulating evidence about harms associated with marijuana use in regards to accidents, impaired driving, psychosis, depression, and suicide; and

Whereas, There is little long term data on the efficacy and potential harms associated with medical or non-medical use; and

Whereas, Practicing clinicians could provide better recommendations for medicinal use with high quality research; and

Whereas, There is emerging data from the states which have legalized marijuana use; and

Whereas, Review and analysis of the emerging data would be helpful to state medical societies as they provide advice to their governmental representatives and regulators as they formulate policies toward marijuana; therefore be it

RESOLVED, That our American Medical Association review pertinent data from those states that have legalized marijuana. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-19)

Introduced by: New York

Subject: Regulating Liquid Nicotine and E-Cigarettes

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Warnings have been placed on liquid nicotine as “poisonous if swallowed, inhaled or if it comes in contact with skin”; and

Whereas, Warnings to “keep out of children’s reach” as liquid nicotine can be addictive, may increase heart rate, blood pressure, cause dizziness, nausea, and aggravate respiratory conditions; and

Whereas, Warnings that “ingestion of liquid nicotine may be fatal”; and

Whereas, Many states have prohibited the sale of tobacco products, liquid nicotine, e-cigarettes and smoking paraphernalia to persons under 21 years of age; and

Whereas, According to the NIH- National Institute on Drug Abuse: teens are more likely to use e-cigarettes than cigarettes (eighth grade 3.6% vs 9.5%) and teen e-cigarette users are more likely to start smoking (8.1% vs 30.7%) and 66% of teens claim “just flavoring” is in their e-cigarettes; and

Whereas, According to the NIH- National Institute on Drug Abuse: “more than 1 in 10 eighth graders say they vaped nicotine in the last year and surveys show vaping among high school seniors increased from 11% in 2017 to 20.9% in 2018; therefore be it

RESOLVED, That our American Medical Association seek legislation or regulations that limit higher concentration nicotine salts (greater than 10mg) in nicotine vaping pods and restrict bulk sale of vaping products and associated paraphernalia. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-19)

Introduced by: New York

Subject: End the Epidemic of HIV Nationally

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, In 2014, Governor Andrew Cuomo announced a New York State (NYS) initiative to End the HIV Epidemic by 2020 (EtE 2020) with the goal of fewer than 750 new HIV infections statewide by 2020; and

Whereas, EtE 2020 is built on New York State's public health leadership since the emergence of AIDS in 1988; and

Whereas, EtE 2020 has a 3-point plan that:

1) Identifies persons with HIV who remain undiagnosed and link them to health care;
2) Links and retains persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; and
3) facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative; and

Whereas, The NYS initiative is at the forefront of similar efforts nationwide and globally as evidenced by a detailed 2015 Blueprint to End the AIDS Epidemic (health.ny.gov/ete) that includes recommendations that address health care and the social determinants of health; and

Whereas, NYS 2017 surveillance data shows a decrease in incidence of new HIV infections statewide; and

Whereas, New York’s End the Epidemic is an example of state’s efforts that can be replicated on the national level; and

Whereas, The are similar state efforts underway to curtail the epidemic; and

Whereas, Federal funds are critical to this effort; therefore be it

RESOLVED, That our American Medical Association advocate that the federal budget include provisions to End the HIV epidemic and that such a plan be structured after New York State's EtE 2020 or other similar state programs. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-19)

Introduced by: Oklahoma

Subject: Patient Medical Marijuana Use in Hospitals

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, By 2018, 33 states, the District of Columbia, Guam, and Puerto Rico, have passed legislation to legalize medical marijuana, including Oklahoma; and

Whereas, There are many legal implications due to the passage of state medical marijuana laws and the associated regulations passed by State Departments of Health; and

Whereas, Many community facilities continue to ban marijuana on their campuses pursuant to the Federal Drug-Free Schools and Communities Act, the Drug-Free Workplace Act, and the Federal Controlled Substance Act; and

Whereas, Hospital medical staffs are struggling when patients with medical marijuana licenses report non-FDA approved marijuana products as home medication and bring these products into their facilities; and

Whereas, American Medical Association Council on Science and Public Health Report 5, I-17, "Clinical Implications and Policy Considerations of Cannabis Use," does not address patient non-FDA approved medical marijuana use in hospitals; therefore be it

RESOLVED, That our American Medical Association offer guidance to medical staffs regarding patient use of non-US Food and Drug Administration approved medical marijuana and cannabinoids on hospital property, including product use, storage in patient rooms, nursing areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-19)

Introduced by: Oklahoma

Subject: Distracted Driver Legislation

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, National Highway Traffic Safety Administration, primarily uses distracted driving to mean "the inattention that occurs when drivers divert their attention away from the driving task to focus on another activity"[1]; and

Whereas, Oklahoma has laws that restrict cell phone use while driving in an effort to reduce distracted driving accidents. Oklahoma is like most states in that many drivers either don't know the applicable distracted driving laws or choose to ignore them; and

Whereas, Nearly one-third of all U.S. drivers 18 to 64 years old read or send text or email messages while driving[2]; and

Whereas, Reading or sending text or email messages while driving and other distracted driving behaviors leads to more than 420,000 injuries and more than 3,100 deaths every year in the United States[3]; and

Whereas, Simply knowing the risks of distracted driving has not yet translated into reducing the behavior[4]; and

Whereas, In 2015, Oklahoma became the 46th state to ban texting while driving. The Oklahoma law, Trooper Nicholas Dees and Trooper Keith Burch Act of 2015 , prohibits texting and some other forms of electronic communication--such as taking photos or video and posting to social media--while operating a motor vehicle; and

Whereas, Some states' laws prohibit drivers from talking on hand-held devices all together; some laws apply only to vehicles in motion whereas others also apply to drivers stopped in a travel lane. Laws focused specifically on electronic communication, or "texting," also vary in prohibited conduct. Some statutes prohibit particular behaviors, such as composing, viewing, or transmitting electronic communications, but do not outlaw other actions such as entering a phone number or entering GPS data; and

Whereas, All states put a legal responsibility on drivers to operate in a safe manner, distracted driving laws vary across the United States in what they prohibit and how they can be enforced; and

Whereas, Federal law bans cell phone use while operating commercial motor vehicles or transporting hazardous materials. Specifically, in 2010 and 2011, Federal law banned commercial truck drivers, bus drivers, and drivers transporting hazardous materials from using hand-held cell phones and messaging on electronic devices[5]; and

Whereas, Current AMA Policy, H-15.952, "The Dangers of Distraction While Operating Hand-Held Devices," merely states "Our AMA will endorse legislation that would ban the use of hand-held devices while driving"; therefore be it

RESOLVED, That our American Medical Association actively lobby for federal legislation to decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle; (Directive to Take Action) and be it further

RESOLVED, That our AMA actively lobby for federal legislation to require automobile manufacturers to integrate hands-free technology into new automobiles. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

RELEVANT AMA POLICY

The Dangers of Distraction While Operating Hand-Held Devices H-15.952

1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.
2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

Citation: (Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13; Modified in lieu of Res. 414, A-15

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[4] Atchley, P., Hadlock, C., & Lane, S. (2012). Stuck in the 70s: The role of social norms in distracted driving, Accident Analysis & Prevention, 40, 279-284.
[5] 49 CFR § 392.80 and § 392.82. https://www.fmcsa.dot.gov/regulations

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-19)

Introduced by: Oklahoma

Subject: Non-Medical Exemptions from Immunizations

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Non-medical exemptions from immunizations endanger the health of unvaccinated individuals, medically exempt patients, and the health of those in his or her group and the community at large; and

Whereas, Vaccinations are critical to protect the health and welfare of Oklahomans; and

Whereas, The Oklahoma State Medical Association supports all efforts to increase vaccination of Oklahoma children; and

Whereas, Oklahoma State Medical Association endorses requiring day care centers and homes to use the recommendations of the Advisory Committee on Immunization Practices as the rules and regulations governing the specific number of vaccine doses required and frequency of their administration to attend day care; and

Whereas, AMA public health policy encourages state medical associations to seek removal of non-medical exemption in statutes requiring mandatory immunizations, including for childcare and school attendance and encourages physicians to grant vaccine exemption requests only when medical contraindications are present (AMA Policy H-440.970); and

Whereas, All states require immunizations for children to attend school. Forty-seven states, all but California, Mississippi, and West Virginia, allow parents to opt out of immunizations if they have religious beliefs against immunizations; and

Whereas, Oklahoma is one of 18 states that allow parents to opt out of vaccines if they have a personal, moral or philosophical belief against immunizations; and

Whereas, In 2016 American Academy of Pediatrics took a stance that personal and religious exemptions should end; and

Whereas, According to the World Health Organization, there has been a 30% increase in measles worldwide in 2017; and

Whereas, The World Health Organization issued a report in January 2019 that said “vaccine hesitancy” has become a global health threat; and

Whereas, In 2019 a measles outbreak has prompted a public health emergency in Washington State; therefore be it

RESOLVED, That our American Medical Association actively advocate for federal legislation that incentivizes states to eliminate non-medical exemptions to mandated pediatric immunizations. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/15/19

RELEVANT AMA POLICY

Nonmedical Exemptions from Immunizations H-440.970
Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.
Citation: (CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-19)

Introduced by: Pennsylvania

Subject: Improved Health in the United States Prison System through Hygiene and Health Educational Programming for Inmates and Prison Staff

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Overcrowding, poor hygiene, and poor-quality food predispose inmates to many preventable diseases; and

Whereas, Lapses in food safety by prison staff have made United States prisoners six times more likely to contract a foodborne illness, such as Clostridium perfringens or Salmonella, than the general population according to a study from the Centers for Disease Control and Prevention (CDC);[2] and

Whereas, Preventing inmates from transmitting illnesses by contact with prison staff, health care providers, and visitors from the community through increased health awareness can contribute to improved community health; and

Whereas, A research study showed that increased hand hygiene was associated with a 24% reduction in the risk of MRSA acquisition. This risk decreased significantly (by 48%) with hand hygiene compliance levels above 80%. Two additional clinical studies supported this data, showing lower incidence rates of MRSA, resistant E. coli and carbapenem resistant P. aeruginosa when achieving compliance levels higher than 70%;[3] and

Whereas, Existing AMA-MSS policy recognizes the importance of oral health as a part of overall patient care and supports an increase in access to oral health services (440.058MSS); and

Whereas, Poor oral health may contribute to the development of endocarditis, cardiovascular disease, and premature birth or low birth weight, and it is typically affected by existing conditions such as diabetes, HIV/AIDS, osteoporosis, and Alzheimer's disease. Risk for poor oral hygiene is high in prison inmates as 1.5% of all inmates in state and federal prisons have HIV or AIDS (21,987 persons), which is 4 times the prevalence rate of HIV in the general populace;[4,5] and

Whereas, Existing AMA policy focuses on increasing health literacy among populace to remove barriers to effective medical diagnosis and treatment through the development of literacy appropriate, culturally diverse, health-related patient education materials (H-160.931); and

Whereas, Adults with limited literacy skills are less likely to manage their chronic diseases and more likely to be hospitalized than people with stronger literacy skills. Only 12 percent of adults have proficient health literacy, according to the National Assessment of Adult Literacy. In other words, nearly 9 out of 10 adults may lack the skills needed to manage their health and prevent disease;[1] therefore be it

RESOLVED, That our American Medical Association collaborate with state medical societies to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in state and local prison systems. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

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[5] Oral health: a window to overall health. Mayo Clinic. 2016 Apr. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-2004747.
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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.
Citation: (CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13

Health Information and Education H-170.986
(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.
(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.
(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous

substances are being used or produced at the worksite.
(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.
(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.
(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.
(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.
(8) Information on health and health care should be presented in an accurate and objective manner.
(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.
(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.
(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.
(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.
(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15

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

440.058MSS Importance of Oral Health in Medical Practice: AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services. (MSS Res 22, I-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-19)

Introduced by: Washington

Subject: Eliminating the Death Toll from Combustible Cigarettes

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The United States has made great progress in decreasing cigarette smoking since the first Surgeon General's report in 1964; and

Whereas, Combustible cigarettes continue to kill between 450,000 and 500,000 people each year in the United States; and

Whereas, The death toll from all other forms of nicotine is very small and not statistically measurable; and

Whereas, There are many other nicotine-delivering products available to U.S. consumers; and

Whereas, The level of measurable toxins in non-combustible nicotine products is much lower than in combustible products; and

Whereas, Safety concerns (real or imagined) have inhibited smokers' understanding of the benefits of product switching; and

Whereas, Wise regulation and medically accurate labeling can address safety concerns about non-combustible nicotine products; therefore be it

RESOLVED, That our American Medical Association study and report on the conditions under which our country could successfully eliminate the manufacture, distribution, and sale of combustible cigarettes and other combustible tobacco products at the earliest feasible date. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

RELEVANT AMA POLICY

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

H-495.986 Tobacco Product Sales and Distribution
Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-19)

Introduced by: Washington

Subject: Universal Access for Essential Public Health Services

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, We have not gained a general consensus on what are the essential public health services that everyone in our country are entitled to receive; and

Whereas, Public health governance structures and funding sources greatly vary by region, state, and jurisdiction across the country; and

Whereas, Compartmentalized, competitive, unpredictable, and inflexible funding leaves many health departments without financing for all essential public health services and necessary capabilities; and

Whereas, Hospitals play an important role in local public health systems and possess enormous capacity to provide essential public health services in a cost-effective manner; and

Whereas, We have no means to accurately capture capabilities and spending on essential public health services in every jurisdiction in order to determine if there is a current lack of universal access; and

Whereas, We have no means of collecting outcome data in order the monitor the access to and cost effectiveness of our public health interventions; therefore be it

RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:

1. A list of all essential public health services that should be provided in every jurisdiction in the United States.
2. A federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services.
3. A federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/26/19

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3. Foundational Public Health Services Model Version 1.0. Public Health National Center for Innovations. Access at: https://phnci.org/uploads/resource-files/PHNCI-FPHS-Factsheet_FINAL-1.pdf
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RELEVANT AMA POLICY

Federal Block Grants and Public Health H-440.912

(1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information.
(2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs.
(3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues.
(4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b) monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs.
(5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.
6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block

Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.
Citation: (CSA Rep. 3, A-96; Reaffirmation A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed in lieu of Res. 424, A-11; Appended: Res. 935, I-11; Reaffirmation A-15

Support for Public Health D-440.997
1. Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members? patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass.
2. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes.
3. Our AMA recognizes the importance of timely research and open discourse in combatting public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.
Res. 409, A-99 Modified CLRPD Rep. 1, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 206, A-13 Reaffirmation A-15 Appended: Res. 902, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-19)

Introduced by: Resident and Fellow Section

Subject: Coordinating Correctional and Community Healthcare

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The United States has the highest rate of incarceration in the world[1] with an estimated 6,899,000 individuals held under the supervision of the correctional system at year end 2013[2]; and

Whereas, The incarcerated population has higher rates of many chronic diseases, including tuberculosis, HIV, hepatitis, asthma, mental health disorders, and substance abuse than the general public[3]; and

Whereas, The increased aging of the prison population will only increase the rates of chronic medical conditions[4]; and

Whereas, The health benefits gained through incarceration, such as food, housing, medication, and access to healthcare are lost upon release, as shown by the increased rate of all-cause mortality in the two weeks following release, as well as the increased rate of hospitalization among recently released inmates compared to the general public and the increased utilization of the emergency department and acute care settings[5-6]; and

Whereas, Health benefits have been demonstrated from the linkage of care from correctional institutions to community health clinics and resources, with poorer chronic health outcomes seen in those not linked to care on reentry compared to those linked tocare, as well as decreased utilization of emergency department in those linked to community health care upon release[7-8]; therefore be it

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[1] Cloud DH, Parsons J, Delany-Brumsey A. Addressing mass incarceration: a clarion call for public health. *Am J Public Health*. 2014;104(3):389-391.

[2] Glaze LE, Kaeble D. Correctional populations in the United States, 2013. Bureau of Justice Statistics; 2014. Available at http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5177(www.bjs.gov). Accessed April 1, 2016.

[3] Marks JS and Turner N. The critical link between health care and jails. *Health Affairs*. 2014: 33(3): 443-447.

[4] Williams BA, Goodwin JS, Baillargeon J, Ahalt C, Walter LC. Addressing the aging crisis in U.S. criminal justice health care. *J Am Geriatr Soc*. 2012;60(6):1150-1156.

[5] Binswanger IA, Stern MF, Deyo RA, et al. Release from prison--a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165.

[6] Frank JW, Linder JA, Becker WC, Fiellin DA, Wang, E. Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey. *JGIM*. 29(9): 12256-33.

[7] Montague BT, Rosen DL, Sammartino C, et al. Systematic Assessment of Linkage to Care for Persons with HIV Released from Corrections Facilities Using Existing Datasets. *AIDS Patient Care STDS*. 2016;30(2):84-91.

[8] Montague BT, Rosen DL, Sammartino C, Costa M, Gutman R, Solomon L, Rich J. Systemic assessment of linkage to care of persons with HIV released from corrections facilities using existing databases. *AIDS Patient Care and STDs.* 2016: 30(2): 84-91.

RESOLVED, That our American Medical Association support linkage of those incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this vulnerable patient population, as well as adequate funding (New HOD Policy); and be it further

RESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

RELEVANT AMA POLICY

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Citation: (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Health 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.
Citation: CMS Rep. 02, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-19)

Introduced by: Resident and Fellow Section

Subject: Contraception for Incarcerated Women

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The United States accounts for over 30% of the world's population of incarcerated women[1] and currently houses more than 200,000 female prisoners[2]; and

Whereas, The population of females in jail or prison worldwide has risen 53% since the year 2003; and

Whereas, The majority of incarcerated women in the United States are between the ages of 18 and 44, and therefore are within reproductive age 4; and

Whereas, Up to 84% of incarcerated women have had a prior unintended pregnancy[5], 77-84% of incarcerated women plan to be sexually active within six months of release[6] and 72% of incarcerated women were not using a regular form of contraception prior to incarceration; and

Whereas, The majority of women incarcerated have multiple barriers to accessing healthcare upon release from jail, and incarceration provides a unique opportunity to provide healthcare to a resource poor population; and

Whereas, Our AMA has policy which advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females and encourages improved access to comprehensive physical and behavioral health care services to adults and juveniles while incarcerated; and

Whereas, Our AMA has policy that 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; therefore be it

RESOLVED, That our American Medical Association support incarcerated persons' access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision-making prior to release. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1 Kajstura, Alexis. (2018), "States of Women's Incarceration: The Global Context 2018" Prison Policy Initiative. URL https://www.prisonpolicy.org/global/women/2018.html, accessed August 31, 2018.
2 Walmsley, R (2017). World Female Imprisonment List, Fourth Edition. Institute for Criminal Policy Research.
3 Kajstura, Alexis (2017), "Women's Mass Incarceration: The Whole Pie 2017". Prison Policy Initiative. URL https://www.prisonpolicy.org/reports/pie2017women.html Accessed August 31, 2018.
4 Carson, AE (2018), "Prisoners in 2016" (No. NCJ 251149), Department of Justice, Bureau of Justice Statistics, Washington DC.

5 Clarke, JG; Hebert, MR; Rosengard, C; et al. “Reproductive healthcare and family planning needs among incarcerated women”, Am Journal Public Health, Vol 96, p. 834-839.
6 Larocelle, F; Castro, C; Goldenson, J; Tulsky, JP; et al. (2012), “Contraceptive use and barriers to access among newly arrested women”, J Correct Health Care, Vol 18, p. 111-119.
7 Oswalt, K; Hale, GJ; Cropsey, KL; et al. (2010), “The contraceptive needs for STD protection among women in jail”, Health Educ. Behav. Off. Publ. Soc. Health Educ., Vol 37, p. 568-579.

RELEVANT AMA 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.
Citation: CMS Rep. 02, I-16

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Citation: (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Reducing Unintended Pregnancy H-75.987
Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.
Citation: Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-19)

Introduced by: Resident and Fellow Section

Subject: Promoting Nutrition Education Among Healthcare Providers

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The prevalence of obesity in the United States is on the continuous rise unchecked, with more than one-third of the population being obese; and

Whereas, The growing burden of obesity is enormous, with about $68 billion direct medical costs and 280,000 deaths each year [1]; and

Whereas, Millions of people in the US file for disability each year[2]; and

Whereas, Clinicians tend to focus more on the complications of obesity such as hypertension, Type II Diabetes and coronary artery disease. However, the importance of primary prevention in early identification and intervention of obesity is seldom discussed by physicians; and

Whereas, The common misconception that nutrition counseling is not their role, but rather the function of dieticians, is still prevalent among healthcare providers; and

Whereas, Some of the important barriers to counseling include lack of nutrition knowledge and skills in nutrition counseling among the medical practitioners.[3] Physicians often do not feel comfortable, confident, or adequately prepared in discussing their patients' diet[3]; and

Whereas, Targeting the dietary habits of our patients and preventing obesity offers a tremendous opportunity to optimize the overall quality of patient care, improve clinical outcomes, and reduce overall healthcare costs; and

Whereas, Nutrition knowledge appears confined largely to books and exams. In fact, according to one study, doctors engage in nutrition counseling with patients only 11% of the time3; and

Whereas, In teaching hospitals, where residents work closely with patients, it is crucial that residents develop a comprehensive knowledge of nutrition science and apply that knowledge to clinical practice; therefore be it

RESOLVED, That American Medical Association Policy H-150.995, "Basic Courses in Nutrition," be reaffirmed (Reaffirm HOD Policy); and be it further

RESOLVED, That AMA Policy H-150.953, "Obesity as a Major Public Health Problem," be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1. Tremmel M, Gerdtham U-G, Nilsson PM, Saha S. Economic burden of obesity: A systemic literature review. Int J Environ Res Public Health.2017; 14(4):435.
2. Lazarus K, Weinsier RL, Boker JR. Nutrition knowledge and practices of physicians in a family-practice residency program: the effect of an education program provided by a physician nutrition specialist. Am J Clin Nutr.1993; 58:319-25.
3. Vetter ML, Herring SJ, Sood M, Shah NR, Kalet AL. What do resident physicians know about nutrition? An evaluation of attitudes, self-perceived proficiency and knowledge. J Am Coll Nutr.2008; 27(2):287-298.

RELEVANT AMA POLICY

Basic Courses in Nutrition H-150.995
Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels.
Citation: (Sub. Res. 116, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-11

Obesity as a Major Public Health Problem H-150.953
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;
(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;
(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;
(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;
(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;
(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;
(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and
(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
Citation: (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-19)

Introduced by: American Academy of Pediatrics

Subject: Mandatory Immunizations for Asylum Seekers

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The current recommended process for immunization of asylum seekers to the United States involves immunization assessment and as indicated vaccine administration in overseas camps prior to embarkment to the US; and

Whereas, Refugees are currently not legally required to get vaccinations before US resettlement; and

Whereas, There currently exists a partnership between the CDC, the Bureau of Population, Migration, and Refugees, and the Department of State; and

Whereas, The vaccinations are provided at reduced price through the Unicef Program; and

Whereas, The increase in asylum seekers who are entering the US by foot without prior positioning in an overseas camp situation makes vaccination prior to arrival impossible; and

Whereas, There remains a resurgence of vaccine-preventable diseases being disseminated during the asylum seeker's journey and processing, in addition to that among current US residents; and

Whereas, Current US residents are eligible to receive Vaccine for Children (VFC) immunizations at considerably reduced cost; and

Whereas, Immunizations remain one of the greatest health promotion accomplishments of our time; therefore be it

RESOLVED, That our American Medical Association call for asylum seekers to receive all medically-appropriate vaccinations upon presentation for asylum regardless of country of origin. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-19)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Approximately 6,000 individuals per day sustain a traumatic brain injury (TBI) in the US[1]; and

Whereas, In 2017, approximately 1.4 million people made at least one suicide attempt and of those successful, 50.57% were achieved by firearms[2]; and

Whereas, People with TBI are twice as likely to commit suicide; and Veterans, a large population of whom have a TBI are also twice as likely to commit suicide[3,4,5,6]; and

Whereas, A systematic review has found that 18% of persons affected by brain injury have attempted suicide and were successful 3–4 times more often than the general population[1]; and

Whereas, Federal law (49 USC 31113(a)(8), 49 CFR 391.41-49) states that medical clearance is required for interstate commercial travel along with numerous states having laws promoting or legally requiring physicians to report patients with medical issues that would impair driving; and

Whereas, Many states have specific agencies or committees tasked with aiding the state in determining the safety of individuals based on their medical conditions and/or ability to exercise sound judgment in relation to driving, and in some instances, proper use and storage of a handgun[7,8]; and

Whereas, The AMA has policy focused on decreasing gun related violence and deaths through public campaigning, generalized advocacy, and requests to the US Surgeon General, and has declared gun violence a public health emergency; and

Whereas, The AMA supports physician reporting of impaired or possibly impaired patients to state agencies when relating to their driving abilities; therefore be it

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[1] Zafonte, Ross D., et al. Brain Injury Medicine, 2nd Edition: Principles and Practice. Vol. 2nd ed, Demos Medical, 2013.
[2] American Foundation for Suicide Prevention . Suicide Statistics. https://afsp.org/about-suicide/suicide-statistics/. Accessed March 18, 2019.
[3] Goldstein L, Diaz-Arrastia R. Traumatic Brain Injury and Risk of Suicide. JAMA. 2018;320(6):554–556. doi:10.1001/jama.2018.10825.
[4] Madsen T, Erlangsen A, Orlovska S, Mofaddy R, Nordentoft M, Benros ME. Association Between Traumatic Brain Injury and Risk of Suicide. JAMA. 2018;320(6):580–588. doi:10.1001/jama.2018.10211.
[5] Teasdale TW, Engberg AW. Suicide after traumatic brain injury: a population study. J Neurol Neurosurg Psychiatry. 2001; 71(4): 436–440.
[6] Simpson G, Tate R. Suicidality in people surviving a traumatic brain injury: prevalence, risk factors and implications for clinical management. Brain Inj. 2007; 21(13–14): 1335–1351.271.
[7] Berger JT, Rosner F, Kark P, Bennett AJ. Reporting by physicians of impaired drivers and potentially impaired drivers. The Committee on Bioethical Issues of the Medical Society of the State of New York. J Gen Intern Med. 2000 Sep;15(9):667-72.
[8] Texas Department of State Health Services. Duties of the Medical Advisory Board. Texas Department of State Health Services. https://dshs.texas.gov/medical-advisory-board/. Published March 7, 2019. Accessed March 18, 2019.

RESOLVED, That our American Medical Association reaffirm current AMA policy, H-145.999, "Gun Regulation," stating it supports stricter enforcement of current federal and state gun legislation (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/02/19

RELEVANT AMA POLICY

Ban Realistic Toy Guns H-145.995
The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.
Citation: Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.
Citation: Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18

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.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18

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

Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13

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.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

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 supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Physicians and the Public Health Issues of Gun Safety D-145.997
Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.
Citation: (Res. 410, A-13

AMA Campaign to Reduce Firearm Deaths H-145.988
The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.
Citation: (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.
Citation: CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.
Citation: Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18

E-8.2 Impaired Drivers & Their Physicians
A variety of medical conditions can impair an individuals ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patients medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.
Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patients ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.
To serve the interests of their patients and the public, within their areas of expertise physicians should:
(a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene.
(b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patients ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments.
(c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses.
(d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely.
(e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver:
(i) when the physician identifies a medical condition clearly related to the ability to drive;
(ii) when continuing to drive poses a clear risk to public safety or the patients own well-being and the patient ignores the physicians advice to discontinue driving; or
(iii) when required by law.
(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician.

(g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.
AMA Principles of Medical Ethics: I,III,IV,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

See also:
Brain Injury in Boxing H-470.984
Reduction of Sports-Related Injury and Concussion H-470.954
Boxing Safety H-470.963
Ban on Handguns and Automatic Repeating Weapons H-145.985
Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989
Waiting Period Before Gun Purchase H-145.992 (Recently Modified)
School Violence H-145.983
Increasing Toy Gun Safety H-145.974
Guns in School Settings H-60.947
Guns in Hospitals H-215.977
Prevention of Ocular Injuries from BB and Air Guns H-145.982
Ocular Injuries from Air Guns H-10.961
Prevention of Unintentional Shooting Deaths Among Children H-145.979

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-19)

Introduced by: Georgia

Subject: Distracted Driver Education and Advocacy

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, A higher percentage of U.S. drivers text or use hand-held cell phones while driving compared to drivers in European countries; and

Whereas, The CDC states that in 2016, 3,450 people were killed in crashes involving a distracted driver; and

Whereas, The CDC also found that in 2015, 391,000 people were injured in motor vehicle crashes involving a distracted driver; and

Whereas, One-fourth of all traffic accidents are associated with cell phone use; and

Whereas, Sixteen states and the District of Columbia have laws in place banning hand-held cell phone use and texting; therefore be it

RESOLVED, That our American Medical Association make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and other interested stakeholders (Directive to Take Action); and be it further

RESOLVED, That our AMA explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Estimated cost of $65,000 to implement resolution.

Received: 05/09/19

RELEVANT AMA POLICY

The Dangers of Distraction While Operating Hand-Held Devices H-15.952
1. Our American Medical Association encourages physicians to educate their patients regarding the public health risks of text messaging while operating motor vehicles or machinery and will advocate for state legislation prohibiting the use of hand held communication devices to text message while operating motor vehicles or machinery.
2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.
3. Our AMA: (A) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (B) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (A) supports education on the use of earbuds or headphones in both ears during outdoor

activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (B) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.
Citation: (Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13; Modified in lieu of Res. 414, A-15

Distracted Driver Reduction D-15.993
Our AMA will develop model state legislation to limit cell phone use to hands-free use only while driving.
Citation: Res. 220, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-19)

Introduced by:	Minority Affairs Section American Association of Public Health Physicians
Subject:	Health Care Accreditation of Correctional, Detention and Juvenile Facilities
Referred to:	Reference Committee D (Diana Ramos, MD, Chair)

Whereas, In 1976, the Supreme Court of the United States[1] and other courts ruled that all persons incarcerated in the United States are entitled to "reasonably adequate health care, meaning "services at a level reasonably commensurate with modern medical science and a quality acceptable within prudent professional standards"; and

Whereas, The American Medical Association developed a set of standards for health care provided to prisoners of jails, prisons, and juvenile detention facilities during the 1970s which were later adopted by the National Commission on Correctional Health Care; and

Whereas, There are organizations that have created standards of correctional health care services and support and regularly survey facilities; and

Whereas, Correctional facilities voluntarily seek NCCHC accreditation which involves a review of the facility's condition by external clinical professionals to determine whether they meet NCCHC accreditation; and

Whereas, The American Correctional Association (ACA) provides similar guidelines and an opportunity for voluntary accreditation and compliance monitoring; and

Whereas, Being an accredited facility has distinct advantages including: 1) ensuring proper health care is provided, 2) demonstrating to the public that the facility has taken steps to care for those incarcerated, 3) promoting the health of a vulnerable segment of society and 4) contributing to the welfare of the public by lessening its financial health care burden; and

Whereas, At the present time, only approximately 15% of the nearly 7,000 penal facilities in the United States are accredited; and

Whereas, The Federal government has enacted the First Step Act (Formerly Incarcerated Reenter Society Transformed Safely Transitioning Every Person Act) in its recognition of concerns of incarceration; therefore be it

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References:
[1] Estelle v. Gamble, 429 U.S. 97 (1976).

RESOLVED, That our American Medical Association work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC), American Correctional Association (ACA) and others with accreditation expertise, in developing a strategy to accredit all correctional, detention and juvenile facilities (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be accredited by a national accrediting organization, such as the NCCHC or ACA, no later than 2025. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA 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.
Citation: CMS Rep. 02, I-16

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities
(2) encourage all correctional systems to support NCCHC accreditation
(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and
(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.
Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.
Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

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.
Citation: CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-19)

Introduced by: Michigan

Subject: Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Individuals who are visually impaired or developmentally disabled rely on public and private means for transportation; and

Whereas, The functionality of autonomous or "self-driving" vehicles span a range from almost complete driver engagement to no driver engagement whatsoever; and

Whereas, Implementation of proven autonomous vehicles may result in reduced automobile accidents and occupant injury or death, with the consequence of lower health care costs, improved public safety, and lower automobile insurance cost; and

Whereas, Most autonomous vehicles currently under development are generally at a level where driver monitoring and engagement is essential for safe driving; and

Whereas, Individuals who are visually impaired or developmentally disabled may not meet the requirements necessary for monitoring an autonomous vehicle at the current level of automation, and therefore would not qualify to operate such vehicles; therefore be it

RESOLVED, That our American Medical Association work with the National Transportation Safety Board to support physician input on research into the capability of autonomous or "self-driving" vehicles to enable individuals who are visually impaired or developmentally disabled to benefit from autonomous vehicle technology. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-19)

Introduced by: Michigan

Subject: Dangers of Vaping

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Electronic nicotine delivery systems (ENDS) produce an aerosol by heating a liquid that usually contains nicotine, flavorings and other harmful chemicals; and

Whereas, Nicotine is an addictive drug that can harm the developing adolescent brain; and

Whereas, ENDS aerosol can contain harmful and potentially harmful substances, including nicotine, ultrafine particles, volatile organic compounds, cancer-causing chemicals, and heavy metals such as nickel, tin, and lead; and

Whereas, The health impacts of inhaling such chemicals is still being investigated but preliminary reports indicate that some ingredients could be harmful to the lungs in the long-term; and

Whereas, The United States Surgeon General recently declared youth e-cigarette use an epidemic; and

Whereas, According to the Centers for Disease Control and Prevention, nearly 1 of every 20 middle school students (4.9%) reported in 2018 that they used electronic cigarettes in the past 30 days and nearly 1 of every 5 high school students (20.8%) reported the same; and

Whereas, Although the impact of such utilization remains to be fully appreciated, it is clear the health impacts and the potential of creating significant health risks parallels the early years of tobacco; and

Whereas, Big tobacco markets to youth via sweet flavoring, product design and ads with deliberate intent on addicting future adult users; therefore be it

RESOLVED, That our American Medical Association amend existing policy H-495.986, "Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes," by addition to read as follows:

Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21 and requirements to include warning labels on all electronic nicotine delivery systems (ENDS);
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years and require warning labels on all ENDS, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; and (g) requirements for warning labels on all ENDS;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Received: 05/09/19

References:
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3. Centers for Disease Control and Prevention. Accessed at https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm.

RELEVANT AMA POLICY

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

H-495.986 Tobacco Product Sales and Distribution
Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-19)

Introduced by: Medical Student Section

Subject: Support for Children of Incarcerated Parents

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

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

Whereas, The imprisoned population demographics are disproportionate with the U.S. population, comprised of 30.1% White non-Hispanic, 33.3% Black, and 23.3% Hispanic compared to the U.S. population at 60.7% White non-Hispanic, 13.4% Black/African American, and 18.1% Hispanic[3-4]; 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, Worse health outcomes as a result of parental incarceration disproportionately impact minorities, where 1 in 9 children with incarcerated parents are African American, 1 in 18 are Hispanic, and 1 in 57 are White[5]; and

Whereas, Parental incarceration has been found to be a strong risk factor for long-lasting psychopathology in children, including antisocial behaviors, high risk behaviors, substance use and abuse, and health problems including depression, post-traumatic stress disorder, anxiety, hyperlipidemia, obesity, asthma, migraines, HIV/AIDS, and overall fair/poor health[6-9]; 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 experience up to five times as many additional ACEs as their counterparts without incarcerated parents, such as financial hardship and exposure to drug and alcohol abuse[11-12]; and

Whereas, Early childhood interventions, such as high quality education programs which support 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, Established intervention programs aimed at improving the interactions between children and their incarcerated parents include interventions such as having parents record

themselves reading their child a book and providing incarcerated parents, their children, and the child's interim caregiver with in-person visits, individual counseling and family skill sessions; and

Whereas, Established intervention programs have shown to increase student performance and interest in school, improve familial functioning, and improve parental mental health[15-16;] and

Whereas, Even increased telephone and written letter contact between children and their incarcerated parents resulted in fewer child behavioral problems and improved mental health[17-18]; and

Whereas, Established intervention programs identify arranging visits, 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[19]; 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[20]; and

Whereas, The 115th Congress introduced a House of Representatives resolution (H.Res.623) that recognizes the importance of providing services to children of incarcerated parents[21]; and

Whereas, The House of Representatives passed H.Res.5682 passed which 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[22]; therefore be it

RESOLVED, That our American Medical Association support legislation and initiatives that provide resources and support for children of incarcerated parents. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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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.
Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

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.
Citation: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

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.
Citation: (CMS Rep. 8, I-13

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.
Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

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.
Citation: Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

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.
Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-19)

Introduced by: Medical Student Section

Subject: Compassionate Release for Incarcerated Patients

Referred to: Reference Committee D
(Diana Ramos, MD, 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 over age 55 quadrupling from 6300 to 25,700 between 1993 and 2013[3]; and

Whereas, Cancer and heart disease are the two leading causes of death in prisons and jails, 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, which 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 these individuals must rely on fellow incarcerated people for support[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 can receive early release because these state laws are inconsistent, confusing, do not delineate a clear process, or contain overly strict eligibility criteria[2]; and

Whereas, For example, 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[2]; and

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

Whereas, Thirty incarcerated individuals died from 2011-2016 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, making it often impossible to analyze outcomes[2]; 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[9,10]; and

Whereas, 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, a recidivism rate of 3.5% compared to an average rate of recidivism of 68% within the same period for all prisoners[7,11]; and

Whereas, In 2016, the United States Sentencing Commission adopted a new set of federal compassionate release eligibility guidelines 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[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]; therefore be it

RESOLVED, That our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release (Directive to Take Action); and be it further

RESOLVED, That our AMA promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: CMS Rep. 02, I-16

Support for Health Care Services to Incarcerated Persons D-430.997
Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities
(2) encourage all correctional systems to support NCCHC accreditation

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; and (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities. Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16

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. Citation: AMA President's Address, A-61; Reaffirmed: CLRPD C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: CEJA Rep. 06, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-19)

Introduced by: Medical Student Section

Subject: Eliminating Recommendations to Restrict Dietary Cholesterol and Fat

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The current government-sponsored guidelines for American no longer recommend restriction of 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 currently recommended for diet restriction due to some of their macronutrient components (i.e. saturated fats)[5,6]; and

Whereas, These foods 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, type 2 diabetes, and central obesity, as well as inversely associated with weight gain[9-13]; therefore be it

RESOLVED, That our American Medical Association amend Policy H-150.944, "Combating Obesity and Health Disparities," by addition and deletion to read as follows:

H-150.944 Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of ~~foods and beverages low in fat, added sugars, and cholesterol,~~ healthful foods and beverages. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

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.
Citation: Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

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.
Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18

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.
Citation: Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

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.
Citation: CSAPH Rep. 5, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 03, A-17; Appended: Res. 414, A-17

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.
Citation: Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-19)

Introduced by: Medical Student Section

Subject: Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, Since Human immunodeficiency virus (HIV) is a disease of significant public health importance, states mandate 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 individuals who fail to disclose HIV status to sexual partners if HIV-positive, with many of these laws 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 one million adults and adolescents in the United States were living with HIV and 49 percent 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 with an undetectable viral load suppressed by ART[6-8]; 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 do not differentiate between high risk behaviors and low/negligible risk behaviors, and criminalize spitting, biting, or having sex with someone with an undetectable viral load, and 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 among people who live with HIV that belong to minority groups[11,14]; and

Whereas, Studies suggest HIV disclosure laws increase stigma towards people who live with HIV, 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[11-16]; and

Whereas, The REPEAL HIV Discrimination Act was introduced in Congress in 2017, and seeks to provide states with guidance on best practices for revising discriminatory HIV laws, with support from a broad range of stakeholders[17,18]; and

Whereas, Ontario, Canada (2017) and North Carolina (2018) have removed punitive policies for HIV non-disclosure in people who live with HIV who are adherent to the treatment plan of an attending physician and are known to be virally suppressed for six months prior to sexual exposure[11,19, 20,21]; and

Whereas, California reduced the act of HIV non-disclosure from classification as a felony to a misdemeanor in 2017, making it equivalent with current California law penalizing intentionally exposing another person to contagious, infectious, or communicable disease[8,22]; 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]; 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"; therefore be it

RESOLVED, That our American Medical Association support repealing legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV who have an undetectable viral load. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13

HIV Testing H-20.920

(1) General Considerations
a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;
b) HIV testing should be consistent with testing for other infections and communicable diseases;
c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;
d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;
e) Physicians should work to make HIV counseling and testing more readily available in medical settings.
(2) Informed Consent Before HIV Testing
a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if he or she refuses HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for

consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.
(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.
(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a standard that a second blood sample be taken and tested on all persons found to be seropositive or indeterminate for HIV antibodies on the first blood sample. This practice is also advised for any unexpected negative result;
d) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
e) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate Western blots or other confirmatory procedures;
f) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.
(5) Routine HIV Testing
a) Routine HIV testing should include appropriately modified informed consent and modified pre-test and post-test counseling procedures;
b) Hospitals, clinics and physicians may adopt routine HIV testing based on their local circumstances. Such a program is not a substitute for universal precautions. Local considerations may include (i) the likelihood that knowledge of a patient's serostatus will improve patient care and reduce HIV transmission risk; (ii) the prevalence of HIV in patients undergoing invasive procedures; (iii) the costs, liabilities and benefits; and (iv) alternative methods of patient care and staff protection available to the patient;
c) State medical associations should review and seek modification of state laws that restrict the ability of hospitals and other medical facilities to initiate routine HIV testing programs;
(d) Encourages a review of the evidence for routine HIV testing by the US Preventive Services Task Force; and
(e) Supports coverage of and appropriate reimbursement for routine HIV testing by all public

and private payers.
(6) Voluntary HIV Testing
a) Voluntary HIV testing should be 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.
Citation: (CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10

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.
Citation: CSA Rep. 4, A-03; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

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.
Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Sub. Res. 2, A-14

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959
1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA 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.
Citation: (Res. 523, A-06; Appended: Res. 706, A-13

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.
Citation: CSA Rep. 4, A-03; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-19)

Introduced by: Nebraska, West Virginia

Subject: Transformation of Rural Community Public Health Systems

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, When communities formed governments in the US, most created a public health authority and system with legal authority to monitor environmental hazards and stressors, surveil the health status of the population within its geographic confines and conduct activities to reduce hazards, protect and improve health for their respective population; and

Whereas, Advances to improve health through enhanced monitoring, surveillance and intervention have greatly expanded, most community public health authorities have not been able to effectively and efficiently incorporate these advances to address changing morbidity resulting from new societal conditions; and

Whereas, Factors contributing to this failure of optimal rural public health include but are not limited to:

- Increased prevalence of chronic disease that accompanies an aging population
- Increased prevalence of mental health and addiction disorders leading to increased morbidity and mortality
- Generational changes in family care dynamics
- Limited patient health literacy and understanding of complex disease
- Fragmentation and duplication of services as a result of absent systems of coordination within and between physicians, providers and community-based public health personnel
- Inadequate funding for community-based approaches to addressing and positively impacting social determinants
- Decline of local specialty care for critical specialties that are directly related to the health of a community (e.g., obstetrics)
- Inability to attract qualified public health leadership professionals for rural communities; and

Whereas, Despite these obstacles, the greatest challenge to restoring high quality community public health systems is the ability of local political authorities, health care practitioners and institutions to study and identify these changes and obstacles; and

Whereas, There is a current lack of accountability between local, state and federal authorities to take ownership of rural public health needs; and

Whereas, The nature, intensity and scope of needs and resources vary among community systems while the essential functions to address them do not; therefore be it

RESOLVED, That our American Medical Association work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health

- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities

- Periodically study efforts to optimize rural public health. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Attachment: **Factors influencing community public health systems in the last 50-100 years**

- The increased prevalence of chronic disease. Through early population screening, risk stratification and interventions, the ability to realize subsequent reduction in downstream morbidity has dramatically increased if such care is sought and obtained. Dementia and autism continue to increase with limited interventions.
- The aging of the population. Increased "life span" produces a marked increase in the need for educational, case management, hygiene, nutritional, mobility, transportation, social interaction and other services if this population is to spend their 'extra decade' happy, productive and comfortable ("health span"), rather than victims of preventable morbidity that results in their "ping ponging" among costly institutional, rehabilitation and home health services. Patient and family understanding of care options in terminal situations is a special challenge.
- Change in family dynamics. The extended nuclear family is rare, with many single parents living alone and the historical child caretaker miles removed or lost to opioids.
- Fragmentation, duplication of services/absence of high tech monitoring and communication networks. Many communities lack any overall organizational structure, as well as monitoring and communication systems, to assure high risk individuals are identified, routinely contacted according to their risk status, as well as assuring all service providers share information and avoid duplicating services.
- Stove pipe funding for addressing social determinants and the use of an "insurance" mechanism rather than an integrated community entity. Most individuals do not have insurance to address the cost of "social determinant" services such as rides to a doctor, air conditioner, grocery delivery and home ides. Former football star Joe Namath encourages on TV certain Medicare recipients to ask their doctor about prescribing such "entitlement" services. Joe and many other on Medicare don't need these services or can afford then on their own. Such funds are not provided to communities to reach the most isolated and needy. Inadequate resources are a chronic problem, together with numerous categorically funded programs duplicating certain functions and creating "system" inefficiency.
- Increased mental health and addiction morbidity and mortality. Expanded treatment of these maladies and the prevention of associated secondary disease morbidity and mortality is welcome. However, there is a paucity of research and community efforts to "prevent" such conditions, such as occurred with the decreased use of tobacco by youth.
- Poor bi-directional communication between physicians, institutional providers and community health staff. Dr. Ilana Yurkiewicz's, a Stanford physician, provides a horrifying account of Michael's journey published in the September 28, 2018 The Atlantic (courtesy of Undark Magazine). Communication among patients, practitioners and institutions is a huge problem leading to repeat readmissions and preventable morbidity
- Loss of close-by specialty care, especially in obstetrics. Hospitals continue to close and often the telemedicine and transportation service to assure continuation of quality care are missing.
- Limited health literacy and assistance accessing the health system. Many patients and care takers have little knowledge and ability to access services for which the patient is eligible, criteria can be very complex and there often is no single community number to call for help.
- Inability to attract and adequately compensate trained public health leadership professionals, In many communities there is an absence of trained public health professionals to lead the system.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-19)

Introduced by: New Jersey

Subject: Change in Marijuana Classification to Allow Research

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

Whereas, The use of marijuana has increased due to the medical marijuana program and will increase further when marijuana is legalized for recreational use; and

Whereas, Physicians have to make marijuana related treatment decisions based on data from anecdotal observations and poorly conducted studies; therefore be it

RESOLVED, That our American Medical Association petition the US Food and Drug Administration / US Drug Enforcement Administration to change the schedule classification of marijuana so that it can be subjected to appropriate research. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Reference Committee E

CSAPH Report(s)

01 CSAPH Sunset Review of 2009 House of Delegates Policies

Resolution(s)

501 USP 800
502 Destigmatizing the Language of Addiction
503 Addressing Healthcare Needs of Children of Incarcerated Parents
504 Screening, Intervention, and Treatment for Adverse Childhood Experiences
505 Glyphosate Studies
506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
507 Removing Ethylene Oxide as a Medical Sterilant from Healthcare
508 Benzodiazepine and Opioid Warning
509 Addressing Depression to Prevent Suicide Epidemic
510 The Intracranial Hemorrhage Anticoagulation Reversal Initiative
511 Mandating Critical Congenital Heart Defect Screening in Newborns
512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients
513 Determining Why Infertility Rates Differ Between Military and Civilian Women
514 Opioid Addiction
515 Reversing Opioid Epidemic
516 Alcohol Consumption and Health
517# Compounding
518# Chemical Variability in Pharmaceutical Products
519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment
520# Substance Use During Pregnancy
521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
522# Improved Deferral Periods for Blood Donors
523# Availability and Use of Low Starting Opioid Doses
524# Availability of Naloxone Boxes
525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents
526# Trauma-Informed Care Resources and Settings
527# Increasing the Availability of Bleeding Control Supplies
528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
529# Adverse Impacts of Delaying the Implementation of Public Health Regulations
530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program

Contained in the Handbook Addendum

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-19

Subject: CSAPH Sunset Review of 2009 House of Delegates Policies

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

At its 1984 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, "Sunset Mechanism for AMA Policy"). Under this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of HOD deliberations.

At its 2012 Annual Meeting, the HOD modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

> (1) As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years. (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.

In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the HOD policies from 2009 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

APPENDIX: Recommended Actions on 2009 House Policies and Directives

Number	Title	Recommended Action and Rationale
D-100.974	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Rescind. Accomplished.
D-130.968	Standards of Care During a Mass Casualty Event	Retain in part to read as follows and change to an H-policy: 1. Our American Medical Association acknowledges that, in a mass casualty event, adjustments in the current health and medical care standards may be necessary to ensure that the care provided results in saving as many lives as possible. 2. Our AMA will: (a) continue to participate with relevant stakeholders to ~~develop and~~ disseminate guidance on the issue of the appropriate standard of care in a mass casualty event; (b) encourage state and specialty medical societies to work with state departments of health and other stakeholders as they develop guidance on allocating scarce resources and establishing the standard of care; and (c) encourage the creation of an adequate legal framework at the local, state, and federal levels for providing health and medical care in a mass casualty situation. Citation: (BOT Rep. 2, I-09)
D-135.982	Regulation of Endocrine Disrupting Chemicals	Retain and change to H-policy.
D-135.983	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Rescind. Include the specific standards outlined in this directive to H-135.946, “Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)”.
D-150.979	Appropriate Supplementation of Vitamin D	Retain in part to read as follows and change to an H-policy: Our AMA: 1. supports continued research on vitamin D and its metabolites, particularly long-term studies that address the benefits, adverse outcomes, and potential confounders across all life stage groups; 2. will educate physicians about the evolving science of vitamin D and its impact on health and develop resources about vitamin D for patients; 3. encourages physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status; and ~~4. will monitor the development of new dietary references intakes for vitamin D in 2010 and respond as appropriate~~.

Number	Title	Recommended Action and Rationale
D-350.990	Next Steps Following AMA Apology to African American Physicians	Retain in part to read as follows and change the title to more accurately represent the language in the policy: ~~Next Steps Following AMA Apology to African American Physicians~~ Collaboration with the National Medical Association to Address Health Disparities Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support ~~the Commission to End Health Care Disparities'~~ efforts to increase the cultural competence of clinicians, and reduce health disparities. Citation: (BOT Action in response to referred for decision Res. 606, A-09)
D-440.995	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Rescind. Accomplished.
D-450.968	Best Practices for Patients with Chronic Diseases	Rescind. Accomplished.
D-460.990	Science, Policy Implications, and Current AMA Position Regarding Embryonic/Pluripotent Stem Cell Research and Funding	Retain. Still relevant.
D-460.993	Support of Embryonic Stem Cell Research	Retain with change in title. Convert to an H policy. Support of Embryonic/Pluripotent Stem Cell Research
D-460.996	Medical Genetics	Retain. Still relevant.
D-460.999	Support for Upgrading and Expanding Medical Research Facilities	Rescind. Accomplished by 42 USC 283k(c)2.
D-480.979	Ultrasound Contrast Agents	Retain. Still relevant.
D-515.982	Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse	Retain. Still relevant.
D-60.973	Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths	Retain in part to read as follows: 1. Our AMA will advocate for a ban on the marketing of products such as flavored malt liquor beverages ~~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~~ flavored malt liquor

Number	Title	Recommended Action and Rationale
		beverages as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.
D-95.996	Consensus Statement of the Physician Leadership on National Drug Policy	Retain in part to read as follows and change to an H-policy: Our AMA ~~endorses~~ supports the 1997 Consensus Statement of the Physicians and Lawyers for ~~Leadership on~~ National Drug Policy as a rational approach to informing national drug policy on illegal drugs.
D-95.997	Altered Illicit Substances	Retain. Still relevant.
D-95.999	Reduction of Medical and Public Health Consequences of Drug Abuse: Update	Retain. Still relevant.
H-10.968	Public Health Impact on Railroads	Retain. Still relevant.
H-100.962	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Retain. Still relevant.
H-100.969	Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals	Retain. Still relevant.
H-125.989	Opposition to Payment for Prescription-Switching	Retain. Still relevant.
H-135.941	Air Pollution and Public Health	Retain. Still relevant.
H-135.946	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Retain with the addition of the specific standards included in D-135.983, "Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)." Our AMA supports more stringent air quality standards for particulate matter ~~than those proposed by the EPA Administrator. This position is supported by several medical specialty societies.~~ We specifically request a NAAQS that provides improved protection for our patients which includes: - 12 µg/m3 for the average annual standard - 25 µg/m3 for the 24-hour standard - 99th percentile used for compliance determination
H-135.979	Clean Air	Retain. Still relevant.
H-145.979	Prevention of Unintentional Shooting Deaths Among Children	Retain. Still relevant.
H-15.958	Fatigue, Sleep Disorders, and Motor Vehicle Crashes	Retain in part to read as follows: Our AMA: (1) ~~defines~~ recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

Number	Title	Recommended Action and Rationale
		(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions. (3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep. (**4**) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness-testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment. (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology. (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice. (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state. (8) recommends that states adopt regulations ~~guidelines be developed~~ for the licensing of commercial and private drivers with sleep-related and other medical

Number	Title	Recommended Action and Rationale
		disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries. (9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries. Citation: (CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09)
H-15.999	Automobile Safety Standards	Retain. Still relevant.
H-150.945	Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants	Retain. Still relevant.
H-150.952	Point-of-Sale Warning Signs Regarding Consumption of Raw Shellfish	Retain. Still relevant.
H-160.928	Drug Initiation or Modification by Pharmacists	Retain. Still relevant.
H-160.938	Disease-Specific Self-Management Programs	Retain. Still relevant.
H-170.962	An Updated Review of Sex Education Programs in the United States	Rescind. Covered by H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools”.
H-170.977	Comprehensive Health Education	Retain in part to read as follows: (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 pre - 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 misuse ~~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 misuse ~~abuse~~; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended

Number	Title	Recommended Action and Rationale
		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.
H-20.896	Support of a National HIV/AIDS Strategy	Retain in part to read as follows: Our AMA supports the creation of a National HIV/AIDS strategy, and will work with ~~the White House Office of National AIDS Policy, the Coalition for a National HIV/AIDS Strategy, and other~~ relevant stakeholders ~~bodies~~ to ~~develop a~~ update and implement the National HIV/AIDS strategy.
H-245.973	Standardization of Newborn Screening Programs	Retain. Still relevant.
H-250.989	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Retain with a change in title. ~~Screening Nonimmigrant Visitors to the United States for~~ Global Tuberculosis Control
H-280.952	CMS Interim Final Rule on the Use of Seclusion and Restraints	Retain. Still relevant.
H-280.959	Recycling of Nursing Home Drugs	Retain. Still relevant.
H-345.999	Statement of Principles on Mental Health	Retain in part to read as follows: (1) Tremendous strides have already been made in improving the care and treatment of ~~the emotionally disturbed~~ patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat ~~mental~~ psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive. (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of

Number	Title	Recommended Action and Rationale
		modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs. (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health. (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
H-350.958	Hispanic Population and Access to the US Healthcare System	Rescind. Policy H-160.931 Part 2 covers this topic.
H-350.959	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	Rescind. This policy adopted the guiding principles of the Commission to End Health Care Disparities. Since the Commission no longer exists, it does not make sense to keep a policy that references their guiding principles.
H-420.971	Infant Victims of Substance Abuse	Retain. Still relevant.
H-420.974	Warnings Against Alcohol Use During Pregnancy	Retain. Still relevant.
H-440.857	Placement of Alcohol-Based Hand Sanitizer Dispensers in Highly Trafficked Areas	Retain. Still relevant.
H-440.858	Disease Transmission Via Foods: Public Health Disaster in Waiting	Retain. Still relevant.
H-440.927	Tuberculosis	Retain in part to read as follows with a change in title: Tuberculosis Control Measures ~~Public Health Policy, Compliance and Coercion:~~ The AMA: (1) supports state and local health authorities' ~~the initiative of public health authorities to modernize the health codes of their states on~~ tuberculosis (TB) control programs, including ~~specific authorization for~~ implementation of control orders ~~a Commissioner-ordered program of directly observed therapy~~ for tuberculosis when patient compliance poses a risk to the public; (2) supports ~~the view that~~ directly observed therapy for ~~tuberculosis~~ TB for newly discharged patients from hospitals ~~is seen~~ as ~~desirable~~ routine policy for community control against the evolution of multi-drug resistant strains; (3) ~~supports the view that,~~ recognizes in cases where

Number	Title	Recommended Action and Rationale
		~~when coercive~~ examination, evaluation, treatment or detention are deemed ~~seen as~~ necessary by public health authorities, each decision should be individualized and subject to due process.~~; and~~ ~~(4) recognizes that the control of tuberculosis (TB) in the foreign-born population is critical to the elimination of TB in the United States, and supports current Centers for Disease Control and Prevention (CDC) recommendations on the prevention and control of TB among foreign-born persons.~~
H-440.958	Universal Immunization for Hepatitis B Virus	Retain in part to read as follows: ~~For enhanced effectiveness in decreasing the incidence of hepatitis B in the United States, it appears to be necessary to broaden current immunization strategies. Safe and effective vaccines are available for prevention of the disease but this use is limited by cost. Eradication of the disease on a national and international basis is a definite hope, but may not be possible without the development of antiviral treatments to control or eliminate the virus in the carrier state and in infected vaccine nonresponders. Education about the disease and its transmission is an essential element for any effective program to reduce the incidence of hepatitis B. Therefore,~~ (1) The AMA supports ~~endorses the principle of the universal immunization with hepatitis B vaccine of all infants, adolescents, military recruits, and students entering colleges and technical schools. While the ultimate goal is the complete immunization of all these groups, the process will need to be a gradual one beginning with the immunization of high-risk groups and then the phasing-in of infants, adolescents, and the other groups.~~ the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B. (2) The AMA encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition. ~~(3) The Association supports the immunization of all other risk groups with special emphasis on patients attending sexually transmitted disease clinics and drug rehabilitation centers.~~ ~~(4)~~ (3) The AMA ~~Association~~ supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection. ~~(5)~~ (4) The AMA ~~Association~~ encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators

Number	Title	Recommended Action and Rationale
		and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation. ~~(6) The Association encourages the scientific community to intensify its efforts to find effective therapies for patients infected with hepatitis B virus.~~ ~~(7)~~ (5) The AMA ~~Association~~ encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.
H-440.983	Update on Sexually Transmitted Infections	Retain. Still relevant.
H-45.977	Flu Protection Guidelines for Air Travel	Retain. Still relevant.
H-45.983	Medical Oxygen Therapy on Scheduled Commercial Air Service	Retain. Still relevant.
H-45.997	In-Flight Emergency Care	Retain. Still relevant.
H-450.952	Regional Input Into the Accreditation Process	Retain. Still relevant.
H-460.920	Public Access to Unpublished Research Data	Retain. Still relevant.
H-460.971	Support for Training of Biomedical Scientists and Health Care Researchers	Retain. Still relevant.
H-460.976	Congressional Earmarking of Federal Research Funds	Retain. Still relevant.
H-460.977	Proposed Moratorium on New Animal Patents	Retain. Still relevant.
H-460.994	Support for Careers in Research	Retain. Still relevant.
H-460.995	Support for Careers in Research	Retain. Still relevant.
H-470.962	Cardiovascular Preparticipation Screening of Student Athletes	Retain. Still relevant.
H-470.973	Boxing as an Olympic Sport	Retain. Still relevant.
H-470.980	Hazards of Boxing	Rescind. Covered by H-470.983, “Boxing as a Health Hazard,” and H-470.984, “Brain Injury in Boxing”.
H-478.990	Tobacco Control Content in Electronic Health Records	Retain. Still relevant.
H-480.972	Medical Device Safety and Physician Responsibility	Retain. Still relevant.
H-495.975	Reducing Tobacco Consumption in the Territory of Guam	Rescind. AMA policy supporting tobacco taxes applies to all jurisdictions.
H-5.997	Violence Against Medical Facilities and Health Care	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
	Practitioners and Their Families	
H-50.979	Use of Blood Therapeutically Drawn from Hemochromatosis Patients	Retain. Still relevant.
H-515.965	Family and Intimate Partner Violence	Retain in part to read as follows: (1) Our AMA believes that all forms of family and intimate partner violence (IPV) 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~~ survivors. 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~~ survivors. 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~~ survivors 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

Number	Title	Recommended Action and Rationale
		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~~ survivors 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~~ IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either ~~victims~~ survivors or abusers themselves; (h) Give due validation to the experience of IPV ~~victimization~~ and of observed symptomatology as possible sequelae; (i) Record a patient's IPV ~~victimization~~ history, observed traumata potentially linked to ~~the~~ IPV ~~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~~ survivors 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~~ survivors and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or join state and local health

Number	Title	Recommended Action and Rationale
		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~~ survivors of intimate partner violence if the required reports identify ~~victims~~ survivors. 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'~~ survivors' identities; (b) allow competent adult ~~victims~~ survivors 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

Number	Title	Recommended Action and Rationale
		pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
H-55.977	Male Breast Cancer	Retain. Still relevant.
H-60.946	Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment	Retain. Still relevant.
H-90.974	Opposition to Obesity as a Disability	Retain. Still relevant.
H-95.955	Physician Impairment	Retain in part to read as follows: (1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of illnesses with the potential to cause impairment ~~problems~~ that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician illness with the potential to cause impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.
H-95.962	Inhalant Abuse	Retain. Still relevant.
H-95.975	Substance Use Disorders as a Public Health Hazard	Retain. Still relevant.
H-95.976	Drug Abuse in the United States – the Next Generation	Retain in part with a change in title to read as follows: ~~Drug Abuse in the United States – the Next Generation~~ Addiction and Unhealthy Substance Use Our AMA is committed to efforts that can help the

Number	Title	Recommended Action and Rationale
		~~this~~ national problem of addiction and unhealthy substance use 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~~ addiction; (2) encourages the development of ~~model substance abuse~~ addiction 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 Substance Abuse and Mental Health Services Administration ~~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~~ use disorder 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~~ addiction 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

Number	Title	Recommended Action and Rationale
		(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 HOUSE OF DELEGATES

Resolution: 501
(A-19)

Introduced by: Virginia; American Association of Clinical Urologists; American College of Allergy, Asthma and Immunology; Kansas; South Carolina; Louisiana; Maryland

Subject: USP 800

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, USP <800> becomes effective December 1, 2019 and describes hazardous drug handling related to the receipt, storage, compounding, dispensing, administration, and disposal of both sterile and nonsterile products and preparations in all locations including physician offices; and

Whereas, USP <800> is mainly applicable to large pharmacies and hospitals which employ pharmacists, pharmacy technicians, etc.; and

Whereas, United States Pharmacopeia (USP) standards such as USP <800> are enforced by local, state and federal regulatory agencies such as The Joint Commission, the US Food and Drug Administration, the Centers for Medicare and Medicaid Services, and some state licensing boards; and

Whereas, The National Institute for Occupational Safety and Health (NIOSH) develops risk assessment levels for antineoplastic and other hazardous drugs in healthcare settings; and

Whereas, There is some debate about the NIOSH categorization of some medications previously given safely in the office setting; and

Whereas, USP expressly defined administration as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use in USP Chapter 797 update to be published on June 1, 2019 in the USP-NF, a combination of two compendia, the United States Pharmacopeia (USP) and the National Formulary (NF); and

Whereas, USP defines compounding as the mixing of two or more FDA-approved drugs or ingredients, with exceptions; and

Whereas, National specialty societies can develop white papers/best practices for the safe and appropriate handling of medications utilized in physician offices and systems for ongoing monitoring of potential complications; and

Whereas, If all of the new USP <800> requirements for preparation of medications in the office setting are implemented December 1, 2019, patient access to proven therapies will decrease, costs will increase, and patient harm may result from not receiving needed treatment in a timely manner; therefore be it

RESOLVED, That our American Medical Association adopt as policy that physicians and other health care providers administering medications (defined as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use) not be subject to the USP 800 compounding guidance (New HOD Policy); and be it further

RESOLVED, That our AMA support development of specialty specific white papers/best practices and systems for both safe medication administration practices and ongoing monitoring of potential complications from the administration of medications deemed suitable for exemptions from the National Institute for Occupational Safety and Health, United States Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of a licensed physician (New HOD Policy); and be it further

RESOLVED, That our AMA continue its working group, consisting of national specialty organizations, state medical societies and other stakeholders to advocate for such exemptions. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 03/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-19)

Introduced by: Young Physicians Section

Subject: Destigmatizing the Language of Addiction

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Addiction is a chronic brain disease[1] and is the most severe form of substance use disorder, a chronic medical illness with potential for both relapse and recovery[2]; and

Whereas, Substance use disorder has been recognized by our AMA as a treatable disease[3]; and

Whereas, 20.1 million Americans have a substance use disorder and only 6.9% receive treatment[4] and 1 in 7 people in the United States will develop a substance use disorder over the course of their lifetime[2]; and

Whereas, Substance use disorder has historically been viewed as a moral failing and social problem rather than a chronic medical illness; and

Whereas, Treatment of substance use disorders has been siloed from mainstream healthcare and patients with substance use disorders have been subjected to discrimination and stigma by the healthcare system and healthcare providers; and

Whereas, Language related to substance use disorders shapes attitudes among healthcare professionals towards patients with addiction and commonly used terms like substance abuse and drug abuser explicitly and implicitly convey that patients are at fault for their disease[5] and influence perceptions and judgments even among highly trained, experienced healthcare professionals[6]; and

Whereas, Negative attitudes among healthcare professionals regarding patients with substance use disorders are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services and poorer patient outcomes[7]; and

Whereas, Existing AMA policy calls for our AMA to take a positive stance as the leader in matters concerning substance use disorders, including addiction[8] and to assist in reducing the stigma associated with substance use[3,9]; and

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[3] AMA Policy, Substance Use and Substance Use Disorders D-95.922
[4] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.
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[7] van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence 2013;131:23– 35.
[8] AMA Policy, Substance Use Disorders as a Public Health Hazard H-95.975
[9] AMA Policy, Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

Whereas, According to the U.S. Surgeon General[2], clinically accurate, preferred terms include "substance use," "substance misuse," "substance use disorder," "recovery,"[3] while non-preferred, stigmatizing terms include "substance abuse," "drug abuser," "addict," "alcoholic," and "clean" or "dirty"; and

Whereas, AMA PolicyFinder includes a topic heading called "drug abuse" and contains over 70 active policy statements that use non-clinically accurate, stigmatizing terminology, because it has not been recognized by our AMA that such terminology can negatively impact physician attitudes and compromise patient care[6,7]; therefore be it

RESOLVED, That our American Medical Association use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty (New HOD Policy); and be it further

RESOLVED, That our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/04/19

RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922
Our AMA:
(1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
Citation: CSAPH Rep. 01, A-18

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;

d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15

Substance Use Disorders as a Public Health Hazard H-95.975
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
Citation: (Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-19)

Introduced by: Missouri

Subject: Addressing Healthcare Needs of Children of Incarcerated Parents

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, The U.S. is the most heavily incarcerated country in the developed world, and five million, or approximately 7% of American children, have an incarcerated parent[1,2]; and

Whereas, Parental imprisonment is recognized as one of several known Adverse Childhood Experiences (ACE), with 64% of children with incarcerated parents experiencing two or more additional adverse events including substance abuse, mental illness, and sexual abuse[1,3]; and

Whereas, Poor health outcomes in children associated with the exposure to parental incarceration include forgone health care, prescription drug abuse, ten or more lifetime sexual partners, higher likelihood of emergency department use, illicit injection drug use, HIV/AIDS, obesity, and behavioral or conduct problems[1,2,4]; and

Whereas, Although efforts have been made to mitigate the harm associated with having an incarcerated parent, few are focused on meeting the direct health needs of children through preventative health care[5]; and

Whereas, Children with incarcerated parents may benefit from initial ACE screening to identify those who require further assessment, health behavioral counseling, or the establishment of a medical home to help them gain access to care[2,6]; therefore be it

RESOLVED, That our American Medical Association support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/16/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-19)

Introduced by: California

Subject: Screening, Intervention, and Treatment for Adverse Childhood Experiences

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, The Centers for Disease Control and Prevention, the Substance Abuse and Mental Services Health Administration, and the American Academy of Pediatrics have all attributed ACEs (Adverse Childhood Experiences) as a contributing factor for mental health and disease states. ACEs can include physical, mental or sexual abuse or neglect. It also includes children who experience divorce, who have a parent with a substance abuse problem or mental illness, or a relative who is incarcerated; and

Whereas, ACEs has been associated with myocardial infarction, COPD, mental distress, depression, smoking, disability, substance abuse, coronary artery disease, Alzheimer's disease, stroke and diabetes. ACEs has also been associated with decreased income, unemployment, lack of health insurance, further victimization as adults of abuse and lower education attainment; and

Whereas, Per the California BRFSS (Behavioral Risk Factor Surveillance System) study, more than 61% of Californians have exposure to at least one ACEs. Identifying and intervening on children early with adequate community, behavioral or mental health resources may benefit children. Adults can be referred for post-trauma treatment or support groups; therefore be it

RESOLVED, That our American Medical Association support efforts for data collection, research and evaluation of Adverse Childhood Experiences (ACEs), cost-effective ACE screening tools without additional burden for physicians, and effective interventions, treatments and support services necessary for a positive screening practice in pediatric and adult populations (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACE screening and trauma-informed care approaches into a clinical setting (New HOD Policy); and be it further

RESOLVED, That our AMA support additional funding sources for schools, behavioral and mental health services, professional groups, community and government agencies to support children and adults with ACEs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/29/19

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; 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.
Citation: (Res. 419, A-11

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.
Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-19)

Introduced by: California

Subject: Glyphosate Studies

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Glyphosate is the most commonly produced herbicide and used on multiple agricultural crops, including corn, soy, canola and wheat, and is found in significant amounts in popular household food products; and

Whereas, The International Agency for Research on Cancer (IARC) under the World Health Organization classified glyphosate as a Group 2A chemical or likely carcinogen in 2015 because emerging research indicates it could potentially cause cell damage; and

Whereas, Research has shown an association between non-Hodkin's lymphoma and glyphosate in human studies and other carcinogenic effects of glyphosate in animal studies; and

Whereas, Research has also shown that glyphosate can damage DNA in the peripheral blood of exposed humans through oxidative stress; and

Whereas, Data shows a significant increase in the use of glyphosate on crops in the past 20 years especially in the United States; and

Whereas, The State of California's Office of Environment Health Hazard Assessment (OEHHA) listed glyphosate (the primary chemical in the herbicide branded Roundup) on the list of chemicals known to cause cancer for the purposes of Proposition 65 which now must carry warnings; therefore be it

RESOLVED, That our American Medical Association advocate for a reduction in the use of glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup), encourage the evaluation of alternatives, and support additional research to determine the long-term effects and association between glyphosate and disease. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-19)

Introduced by: Illinois

Subject: Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Much misleading information is contained in advertising of herbal remedies and dietary supplements; and

Whereas, Herbal remedies and dietary supplements are sold as food but advertised in such a way as to imply some therapeutic effect of their contents; and

Whereas, Americans spend billions of dollars each year on herbal remedies and dietary supplements in the hope that doing so will enhance their own good health in some way; and

Whereas, Herbal remedies and dietary supplements are not regulated by the US Food and Drug Administration and consequently the identities of their ingredients, active or inactive, and their concentrations are mostly unknown; and

Whereas, Herbal remedies and dietary supplements are not subject to strict regulation, therefore they may or may not have the ingredients listed on the label; and

Whereas, Some herbal remedies and dietary supplements have been documented to have active medications not indicated on the label and some have been documented to contain toxic drugs; and

Whereas, Patients seeking relief of symptoms may turn to herbal remedies and dietary supplements before consulting a medical professional and thus delay the proper diagnosis and therapy for their condition; and

Whereas, Any merchandise that claims to have health benefits is not food; therefore be it

RESOLVED, That our American Medical Association work with the National Center for Complementary and Integrative Health (NCCIH), the federal agency responsible for oversight of herbal remedies and dietary supplements, to institute stricter guidelines for advertising and labeling of these products so that consumers will be informed of what they are purchasing (Directive to Take Action); and be it further

RESOLVED, that our AMA support a licensing body through legislation for manufacturers of dietary supplements and herbal remedies, with the requirement that those manufacturers must supply proof that their products have health benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA urge that the increased cost of a stricter NCCIH program on dietary supplements and herbal remedies be paid for by the manufacturers who produce them. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-19)

Introduced by: Illinois

Subject: Removing Ethylene Oxide as a Medical Sterilant from Healthcare

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Ethylene oxide (EtO) is a known human carcinogen as identified by the International Agency for Research on Cancer (IARC) and USEPA. It is used for sterilization of medical equipment that cannot be sterilized by steam. This process is open to the workplace environment at various points allowing the escape of EtO into the area and community. Safer substitution, therefore, should be considered, as alternatives exist that are equally efficacious with respect to sterilization of non-metal products. [6] While many hospitals have switched away from ethylene oxide due to the toxicities, an estimated 80% of non-metallic medical equipment is still being sterilized with EtO at industrial facilities before delivery [6]; and

Whereas, Only 0.05% of the annual production is used for sterilization, sterilization and fumigation is where the highest exposure levels to workers and communities have been measured. [6] Inhaling contaminated air exposes surrounding communities to ethylene oxide when the gas is released from a sterilant facility; and

Whereas, Ethylene oxide exposure is associated with irritation of the respiratory tract, eyes, and skin. [6] With direct contact it can cause burns, blistering, and desquamation of the skin. It can also cause conjunctivitis and contact dermatitis. [6, 4] Acute high-level exposure can cause asthma, and sensitization. [6, 4] It can lead to peripheral neuropathy and central neurotoxicity including neuropsychological abnormalities, and seizures. [4] In animals, exposure has been shown to cause spontaneous abortion, preterm births, and reproductive toxicity in both males and females [4][6]; and

Whereas, In 1984, the International Agency for Research on Cancer (IARC) included ethylene oxide in its list as a probable carcinogen by 2008 with adequate information available only in animals, microorganisms, and invitro. It has been shown to induce sensitive, persistent dose-related frequency of chromosomal aberrations, sister chromatid exchange in peripheral lymphocytes and micronuclei in bone-marrow cells of exposed workers [4][14]; and

Whereas, Epidemiologic studies of humans in 2004, since reviewed by IARC and USEPA, have documented EtO as a Class 1 known human carcinogen. EtO's carcinogenic impact is due to its action as an alkylating agent and specifically has been associated with malignancies of the breast, lymphatic and hematopoietic systems in humans [6][18][19]; and

Whereas, Based on this new information, USEPA changed EtO's adult-based inhalation unit risk from 0.0001 per microgram per cubic meter (µg/m3) to 0.003 per µg/m3, a 30-fold increase in cancer potency. In Willowbrook, Illinois, this elevated the additional lifetime risk of 6.4 cancers in a population of 1,000 residents who could be exposed to EtO emissions from a local industrial sterilizing facility. This cancer risk exceeds U.S. EPA's decision-making cancer risk range of 1.0

x 10-6 to 1.0 x 10-4, and adds to the lifetime background cancer risk of an average American of 1 in 3 people [24] [25]; and

Whereas, For community exposures no regulations exist save the USEPA's advice with respect to carcinogenic risk and the need for action when the risk exceeds the U.S. EPA's decision-making cancer risk range of 1.0 x 10-6 to 1.0 x 10-4; and

Whereas, Due to the impossibility of sterilizing these materials in an enclosed system, safer substitution is the most effective means to address this problem of EtO community exposures. As described by the industry consensus standards Association for the Advancement of Medical Instrumentation, these include radiation sterilization, hydrogen peroxide, nitrogen dioxide and hydrogen peroxide-ozone. The Federal Drug Administration noted in 2016 that hydrogen peroxide was an alternative that they were familiar with and invited applications for sterilization process reviews using this chemical [23]; therefore be it

RESOLVED, That our American Medical Association adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient (New HOD Policy); and be it further

RESOLVED, That our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-19)

Introduced by: New York

Subject: Benzodiazepine and Opioid Warning

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, During 1999–2017, the rate of drug overdose deaths approximately tripled with approximately 70,000 overdose deaths occurring nationally in 2017, nearly 68 percent involving an opioid; and

Whereas, By 2017, fentanyl was involved in 57 percent of all drug overdose deaths in New York City; and

Whereas, Illicitly manufactured fentanyl (a synthetic, short–acting opioid with 50 – 100 times the potency of morphine) has been mixed into heroin, cocaine, and counterfeit pills with or without the users' knowledge, and has increased the risk of fatal overdose; and

Whereas, Benzodiazepines, often used to aid in relieving symptoms like anxiety, are schedule IV substances available through a physician with a high risk for illicit use; and

Whereas, Illicit use of benzodiazepines is becoming more common--especially in teens and young adults; and

Whereas, Benzodiazepines used in excess, can lead to memory loss, dulled emotions, compulsive actions, personality changes and can lead to fatal overdose; and

Whereas, More than 30 percent of overdoses involving opioids also involve benzodiazepines which include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), and others; and

Whereas, The dangers of co–prescribing opioids and benzodiazepines has been well known for many years; and

Whereas, The illegal drug market has been producing illicit alprazolam laced with illicit fentanyl leading to addiction and overdose death; therefore be it

RESOLVED, That our American Medical Association raise the awareness of its members of the increased use of illicit sedative/opioid combinations leading to addiction and overdose death (Directive to Take Action); and be it further

RESOLVED, That our AMA warn members and patients about this public health problem. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.
Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-19)

Introduced by: International Medical Graduates Section

Subject: Addressing Depression to Prevent Suicide Epidemic

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Major depressive disorder affects approximately 14.8 million American adults in a given year, approximately 6.7 percent of the U.S. population age 18 and older and is the leading cause of disability in the U.S. for ages 15-44; and

Whereas, Roughly 40 million American adults ages 18 and older in a given year, or about 18.1 percent of people in this age group, have an anxiety disorder which is frequently coincident with depressive disorders; and

Whereas, Suicide is the 10th leading cause of death each year in the U.S., claiming the lives of nearly 45,000 people and accounting for $50.8 billion in cost; and

Whereas, Suicide is the 2nd leading cause of death for people aged 10–34 and more than 90% of people who die by suicide show symptoms of mental illness especially major depressive or bipolar disorder, and substance use disorders; and

Whereas, One doctor per day or 300-400 U.S. physicians die by suicide each year, according to the American Foundation for Suicide Prevention; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH) and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the CDC, the NIH and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1 U. S. Department of Health and Human Services, https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html, “Does depression increase the risk for suicide?”
2 The National Institute of Mental Health, http://www.nimh.nih.gov, “Major Depression” and “Suicide.”
3 Data on behavioral health in the United States https://www.apa.org/helpcenter/data-behavioral-health
4 Mental health by the numbers https://www.nami.org/learn-more/mental-health-by-the-numbers

RELEVANT AMA POLICY

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4.Our AMA recognizes the impact of violence and social determinants on womens mental health.
Citation: Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991
Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.
Citation: Res. 910, I-17

Depression and Physician Licensure D-275.974
Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.
Citation: (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12

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.
Citation: (Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-19)

Introduced by: Resident and Fellow Section

Subject: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Cerebrovascular disease is the fifth most common cause of mortality in the United States, responsible for 5.2% of deaths nationwide or 140,000 per year[1]; and

Whereas, Intraparenchymal hemorrhages are the most common nontraumatic hemorrhagic stroke and have the highest risk of mortality[2]; and

Whereas, The largest reversible risk factor for poor outcomes in intraparenchymal hemorrhages is use of anticoagulants, such as warfarin[3]; and

Whereas, The effects of anticoagulants can be mitigated with rapid use of newer reversal agents, such as prothrombin complex concentrate, which have replaced transfusion as a standard of care[4]; and

Whereas, Many emergency rooms do not know about new anticoagulation reversal medications or do not know how to use them, resulting in worse outcomes for patients prior to transfer to tertiary centers; and

Whereas, Savings in healthcare expenditures and worker productivity are expected with better patient outcomes, while reversal medications are relatively inexpensive; therefore be it

RESOLVED, That our American Medical Association support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1 Health, United States, 2016: With Chartbook on Long-term Trends in Health. In: Services UDoHaH, ed. Vol 76–641496. Hyattsville, MD2017.
2 Alaraj A, Esfahani DR, Hussein AE, et al. Neurosurgical Emergency Transfers: An Analysis of Deterioration and Mortality. Neurosurgery. 2017.
3 Esfahani DR, Radnis CA, Hussein AE, Amin-Hanjani S, Charbel FT, Alaraj A. Thresholds for Volume and Expansion in Intraparenchymal Hemorrhage: Predictors of Neurologic Deterioration and Mortality. World neurosurgery. 2017.
4 Hemphill JC, 3rd, Greenberg SM, Anderson CS, et al. Guidelines for the Management of Spontaneous Intracerebral Hemorrhage: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46(7):2032-2060.

RELEVANT AMA POLICY

Home Anti-Coagulation Monitoring H-185.951
1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.
2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.
3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.
Citation: (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14

Stroke Prevention and Care Legislation H-425.978
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 stroke prevention and care.
Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11

The Next Transformative Project: In Support of the BRAIN Initiative H-460.904
Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.
Citation: (Res. 522, A-13; Modified: Res. 514, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-19)

Introduced by: Resident and Fellow Section

Subject: Mandating Critical Congenital Heart Defect Screening in Newborns

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Approximately 18 out of every 10,000 infants are born with a critical congenital heart defect (CCHD)[1]; and

Whereas, CCHDs are life-threatening and often require intervention during infancy[1]; and

Whereas, Many CCHDs are not detected prenatally or in the immediate post-natal period[1]; and

Whereas, The pulse oximetry screening protocol is a low-cost and sensitive screen that can be used to detect CCHD; and

Whereas, A 2013 study in *Pediatrics* estimated screening could potentially identify 1,189 more newborns with CCHD at birth hospitals in the United States annually and screening may cost approximately $40,000 per life-year saved, which is considered cost-effective[2]; and

Whereas, Our AMA has policy in support of standardized newborn screening (H-245.973) and newborn hearing screening (H-245.970); and

Whereas, 43 states have taken steps toward newborn screening through legislation, regulations, and hospital guidelines, 35 of which have legislation mandating screening for congenital heart defects[3]; therefore be it

RESOLVED, That our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

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[1] American Academy of Pediatrics. (2018) "Newborn Screening for CCHD." Available at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx

[2] Peterson C, Grosse S, Oster M, Olney R, and Cassell C. Cost-effectiveness of routine screening for critical congenital heart disease in US newborns. *Pediatrics* 2013; 132(3).

[3] Glidewell J, Olney RS, Hinton C, Pawelski J, Sontag M, Wood T, Kucik J; Daskalov R, Hudson J. State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects — United States, 2011–2014. *CDC Weekly Morbidity and Mortality Report.* 19 June 2015: 64(23);625-630.

RELEVANT AMA POLICY

Standardization of Newborn Screening Programs H-245.973
Our AMA: (1) recognizes the need for uniform minimum **newborn screening** (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09)

Early Hearing Detection and Intervention H-245.970
Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing **screening**, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing **screening** of newborns and infants, prompt evaluation and diagnosis of children referred from **screening** programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss. (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-19)

Introduced by: Resident and Fellow Section

Subject: Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Cancer treatments in younger patients can lead to reduced fertility[1]; and

Whereas, Studies have demonstrated that oncology patients are interested in the option of fertility preservation[2]; and

Whereas, There are several methods to help preserve fertility in pediatric and reproductive aged patients including cryopreserving embryos, oocytes, sperm, or gonadal tissue[1]; and

Whereas, Fertility preservation has not been associated with delayed cancer treatment or decreased survival; and

Whereas, There are significant geographic and clinic variations in the support for fertility preservation amongst oncologists and fertility specialists; and

Whereas, There is a lack of adequate provision of information on fertility preservation and lack of referral to fertility clinics for pediatric and reproductive aged oncology patients often resulting from oncologist discomfort in providing adequate counseling to such patients[1]; and

Whereas, There is a significant disparity in access to fertility preservation for pediatric and reproductive aged oncology patients; therefore be it

RESOLVED, That our American Medical Association encourage disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is a possibility (New HOD Policy); and be it further

RESOLVED, That our AMA support education for providers who counsel patients that may benefit from fertility preservation. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

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[1] The Ethics Committee of the American Society for Reproductive Medicine. “Fertility Preservation and Reproduction in Cancer Patients.” *Ethics Committee Report*, Elsevier, Inc, 11 Mar. 2005, oncofertility.northwestern.edu/sites/oncofertility/files/legacy_files/uploadedfilecontent/ASRM_FP_in_Cancer_2005.pdf

[2] National Comprehensive Cancer Network. *NCCN Guidelines Version 2.2018 Adolescent and Young Adult Oncology*. 11 Oct. 2017.

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Code of Medical Ethics: Opinion 2.1.1 Informed Consent
Code of Medical Ethics: Opinion 2.1.3 Withholding Information from Patients
Code of Medical Ethics: Opinion 2.2.1 Pediatric Decision Making

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-19)

Introduced by: Women Physicians Section

Subject: Determining Why Infertility Rates Differ Between Military and Civilian Women

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, According to the Service Women's Action Network (SWAN) December 2018 report, there are more than 369,000 service women (more than 17% of the military) and two million women veterans (10% of veterans population). Further, women comprise 18.5% of all veterans under age 45;[1] and

Whereas, Infertility rates in military women are significantly higher than the general population; and

Whereas, A 2018 SWAN survey found that over 37% of active service women reported having difficulty getting pregnant when actively trying after one year (or longer), which is much higher than the reported rate of the general population;[2] and

Whereas, The Centers for Disease Control and Prevention reports that approximately 12.1%[3] of the general U.S, female population have impaired fecundity, which is a condition related to infertility and refers to women who have difficulty getting pregnant or experience recurrent pregnancy loss;[4] and

Whereas, Twenty percent of active service women and 32% of female veterans reported that they did not seek medical services for infertility and cited location, accessibility, and cost as factors;[2] and

Whereas, Only six military treatment facilities in the U.S. offer a full range of infertility treatments, and there are often long wait times to access these services;[5] and

Whereas, Tricare benefits exclude assisted reproductive technology for veterans, unless it can be demonstrated that a related injury occurred while on active duty;[6] and

Whereas, Some women reported being denied care "unless they can demonstrate their infertility is service connected";[2] and

Whereas, Without insurance, one round of In Vitro Fertilization treatment can cost $15,000 or more, with multiple cycles sometimes required for success ;[2] and

Whereas, Women in the military are exposed to reproductive health hazards that can increase their risk of infertility;[7] and

Whereas, Infertility among service women is often associated with sexual assault and/or combat-related trauma;[8] and

Whereas, In 2018, the U.S. Department of Defense noted that 79 percent of the reports of sexual assault were from women;[9] and

Whereas, Survivors of sexual assault are at risk for acquiring sexually transmitted infections such as chlamydia and gonorrhea, which can lead to pelvic inflammatory disease and infertility; and

Whereas, It is unknown whether the etiology of higher infertility rates among service women is related to unique occupational exposures within the military;[8] therefore be it

RESOLVED, That our American Medical Association advocate for additional research to better understand whether higher rates of infertility in service women may be linked to military service and which approaches might reduce the burden of infertility among service women. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

References:
1. Department of Defense, Defense Manpower Data Center, unpublished data current as of February 28, 2018.
2. Haring, E, et al. (2018 December). Access to Reproductive Health care: The Experiences of Military Women. Retrieved from https://www.servicewomen.org/reports/.
3. Centers for Disease Control and Prevention (CDC-P). National Health Statistics Report (2016 July 15). Available at www.cdc.gov/nchs/fastats/infertility.htm.
4. CDC-P. Reproductive Health. Available at www.cdc.gov/reproductivehealth/Infertility.
5. Tricare and Fertility Treatments. Available at www.military.com/paycheck-chronicles/2017/01/26/tricare-fertility-treatments. Accessed March 2019.
6. Covered Services. Available at www.tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices. Accessed March 2019.
7. van den Berk Clark C, Chang J, Servey J, and Quinlan JD. Women's Health and the Military. Primary Care: Clinics in Office Practice. 2018;45(4): 677-686.
8. Zephyrin, LC. Reproductive health management for the care of women veterans. Obstet Gynecol. 2016;127:383-392.
9. DoD Releases Annual Report on Sexual Assault in Military. Available at dod.defense.gov/News/Article/Article/1508127/dod-releases-annual-report-on-sexual-assault-in-military/. Accessed March 2019.

RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
Citation: CMS Rep. 01, I-16

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.
Citation: Sub. Res. 224, I-15; Reaffirmation: I-17

Recognition of Infertility as a Disease H-420.952
Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.
Citation: Res. 518, A-17

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.
Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-19)

Introduced by: American Medical Women's Association

Subject: Opioid Addiction

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, Sex-based differences in response to opioids can result in women developing opioid addiction more readily than men, even when using lower doses for shorter periods of time; and

Whereas, An increasing number of women are addicted to opioids; and

Whereas, Women of child-bearing age who are using opioids inappropriately may be reluctant to seek health care because of the stigma attached to substance use disorder; and

Whereas, Women who used opioids prior to caesarian section are more likely to require opioids for longer periods of time after the procedure; and

Whereas, Enhanced recovery after surgery (ERAS) protocols for caesarian section have been shown to decrease opioid use during hospitalization and after discharge, while improving mobilization and other outcomes; therefore be it

RESOLVED, That our American Medical Association work with constituent organizations to assure that women of child-bearing age who are using opioids and are accessing the health care system undergo evaluation for pregnancy and, if pregnancy, be offered prenatal care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that women who use opioids prior to caesarian section are offered multi-modalities to control pain and improve function after the procedure with the goal of transitioning to other methods of pain control for long term (Directive to Take Action); and be it further

RESOLVED, That our AMA work with hospitals and relevant constituent organizations to assure that the enhanced recovery after surgery protocol for caesarian section is widely adopted to optimize recovery and improve function while decreasing use of opioid medications for pain, especially given the impact of such use in breast-feeding mothers and their infants. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-19)

Introduced by: American Medical Women's Association

Subject: Reversing Opioid Epidemic

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, Deaths from overdose of opiates are increasing more rapidly in women than men, with an increase of 5-fold in women compared to 3.6-fold in men between 1999 and 2010; and

Whereas, These data may be explained by sex-based differences in chronic pain, response to opioids, and risk of opioid addiction; and

Whereas, Women are more likely to have conditions that lead to chronic pain such as osteoarthritis, inflammatory arthritis, temporal mandibular syndrome, or injuries resulting from intimate partner violence; and

Whereas, Because of sex-based differences in brain signaling pathways and higher prevalence of untreated co-existing depression and PTSD, women may perceive pain more intensely than men; and

Whereas, Sex-based differences in response to opioids can result in women developing opioid addiction more rapidly than men, even when using lower doses for shorter time periods, and having greater issues with addiction treatment; therefore be it

RESOLVED, That our American Medical Association include in their program, Reversing the Opioid Epidemic, education materials for physicians regarding sex-based differences in perception of pain, including the impact of co-morbid conditions, sex-based differences in response to opioids and risks for opioid addiction, and issues with accessing and outcomes of addiction programs among women. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Alcohol Consumption and Health

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, The Global Burden of Diseases, Injuries, and Risk Factors Study 2016[1] found that, despite a protective effect for ischemic heart disease and diabetes, no level of alcohol consumption minimizes the heath loss due all-cause mortality and cancer; and

Whereas, Previous studies suggesting a health benefit for moderate alcohol consumption may have been poorly designed to estimate the full extent of health effects from alcohol due to survival biases, including "sick quitter" hypothesis, and poor study design[2]; and

Whereas, the Global Burden of Diseases, Injuries and Risk Factors Study 2016 found alcohol to be the 7th leading global risk factor for deaths and disability-adjusted life-years; and

Whereas, Alcohol consumption is a recognized modifiable risk factor for several common types of cancer, including liver, esophageal, oropharyngeal, laryngeal, breast and colon[3]; and

Whereas, Between 2006 and 2010, the Centers for Disease Control and Prevention reported that 88,000 deaths[4] were attributed to excessive alcohol consumption in the United States; and

Whereas, Although the greatest risk of cancer is associated with high levels of consumption even light alcohol consumption is associated with a higher risk of esophageal, oral cavity and pharyngeal, and breast cancers with relative risks of 1.26, 1.13, and 1.04 respectively[5]; and

Whereas, The World Cancer Research Fund/American Institute for Cancer Research estimates a 5% increase in premenopausal breast cancer and a 9% increase in postmenopausal breast cancer per 10 grams of ethanol consumed per day[6]; and

Whereas, Consumption of alcohol, without the development of alcoholism or alcohol dependence, is an underappreciated cause of cancer; and

Whereas, Many people engage in excessive drinking without recognition of the risk factors it poses to health, including increased risk of developing cancer; and

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[1] GBD 2016 Alcohol Collaborators. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet.* 392(10152);22-28: 2018.
[2] Burton R, Sheron N. No level of alcohol consumption improves health. Lancet. 392(10152);22-28: 2018.
[3] LoConte, Noelle et al. Alcohol and Cancer: A Statement of the American Society of Clinical Oncology. J Clin Onc 2018 36:1, 83-93.
[4] Centers for Disease Control and Prevention: Alcohol use and health. http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
[5] Bagnardi V, Rota M, Botteri E, et al: Alcohol consumption and site-specific cancer risk: A comprehensive dose-response meta-analysis. Br J Cancer 112:580-593, 2015.
[6] World Cancer Research Fund: Diet, nutrition, physical activity and breast cancer. http://www.wcrf.org/sites/default/files/CUP_BREAST_REPORT_2017_WEB.pdf

Whereas, The International Agency for Research on Cancer classified alcohol as a group 1 carcinogen[7]; therefore be it

RESOLVED, That our American Medical Association recognize alcohol consumption as well as alcohol abuse as a modifiable risk factor for cancer (New HOD Policy); and be it further

RESOLVED, That our AMA support research and educational efforts about the connection between alcohol consumption and several types of cancer (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion to read as follows:

> "…(4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol consumption, ~~abuse,~~ particularly that which leads to illness, cancer, and accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits…" (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993
The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16

Alcohol Abuse and the War on Drugs H-30.972
Our AMA (1) supports documenting the strong correlation between alcohol abuse and other substance abuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between alcohol abuse and other substance abuse and recommendations to decrease the immense number of health, safety, and social problems associated with alcohol abuse. Citation: (Sub. Res. 97, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10

Alcohol Use Disorder and Unhealthy Alcohol Use Among Women H-30.943
The AMA recognizes the prevalence of unhealthy use of alcohol among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol us disorder and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing

[7] World Cancer Research Fund/American Institute for Cancer Research: Food, Nutrition, Physical Activity, and the Prevention of Cancer: A Global Perspective. Washington, DC, American Institute for Cancer Research, 2007.

fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.
Citation: CSA Rep. 5, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: CSAPH Rep. 01, A-17

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.
Citation: CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-19)

Introduced by:	American Academy of Dermatology, American Academy of Cosmetic Surgery, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, Missouri, Florida, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society for Aesthetic Plastic Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Wisconsin, South Carolina, American Vein and Lymphatic Society, New York, Utah, International Society of Hair Restoration Surgery
Subject:	Compounding
Referred to:	Reference Committee E (Leslie H. Secrest, MD, Chair)

Whereas, Our AMA supports appropriate regulatory oversight of compounding pharmacies and facilities engaging in interstate commerce (e.g. compliance with state board of pharmacy and current United States Pharmacopeia and National Formulary compounding standards); and

Whereas, The Drug Quality and Security Act of 2013 increased Food and Drug Administration oversight of compounding pharmacies and has led to burdensome regulatory restrictions on simple preparation of manufacturered FDA-approved medications for the office-based procedures in which aseptic technique is routine and appropriate, such as buffered lidocaine; and

Whereas, Patients risk losing access to safe and effective office-based procedures; and

Whereas, US Pharmacopeia (USP) is currently revising its standards on compounded sterile preparations, Chapter 797, which provides equipment and process requirements that state policymakers (e.g. state pharmacy boards, state medical boards) may adopt; and

Whereas, State policymakers have adopted a variety of restrictions on compounding. but little is known how individual states are interpreting USP Chapter 797 to affect physicians; and

Whereas, More individualized education is needed to help further physician advocacy on this issue; therefore be it

RESOLVED, That our American Medical Association provide a 50-state analysis of state law requirements governing in-office preparation of medications in physicians' offices, including which states have adopted USP Chapter 797 and how compounding is defined by state law (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose any state medical board action to delegate authority or oversight of physicians preparing medications in physicians' offices to another regulatory body (e.g., state pharmacy board) (Directive to Take Action); and be it further

RESOLVED, That our AMA work with medical specialty societies to preserve a physician's ability to prepare medications in physicians' offices and be able to do so without being subject to unreasonable and burdensome equipment and process requirements. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/06/19

RELEVANT AMA POLICY

Pharmacy Compounding H-120.945
Our AMA: (1) recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; (2) encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; (3) supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; (4) supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and (5) in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding.
Citation: BOT Action in response to referred for decision Res. 521, A-06; Revised: CSAPH Rep. 9, A-13; Reaffirmed in lieu of: Res. 817, I-16

USP Compounding Rules H-120.930
1. Our AMA will engage in efforts to convince United States Pharmacopeia (USP) to retain the current special rules for procedures in the medical office that could include but not be limited to allergen extract compounding in the medical office setting and, if necessary, engage with the U.S. Food and Drug Administration (FDA) and work with the U.S. Congress to ensure that small volume physician office-based compounding is preserved.
2. Our AMA will undertake to form a coalition with affected physician specialty organizations such as allergy, dermatology, immunology, otolaryngology, oncology, ophthalmology, neurology, and rheumatology to jointly engage with USP, FDA and the U.S. Congress on the issue of physician office-based compounding preparations and the proposed changes to USP Chapter 797.
3. Our AMA reaffirms that the regulation of compounding in the physician office for the physician's patients be under the purview of state medical boards and not state pharmacy boards.
4. Our AMA supports the current 2008 USP Chapter 797 sterile compounding rules as they apply to allergen extracts, including specifically requirements related to the beyond use dates of compounded allergen extract stock.
Citation: Res. 204, A-16; Reaffirmation: A-17; Reaffirmation: A-18

Appropriate Use of Compounded Medications in Medical Offices H-120.934
Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.
Citation: Res. 207, A-15; Reaffirmed: CMS Rep. 04, A-16; Reaffirmed: Res. 204, A-16; Reaffirmed in lieu of: Res. 817, I-16

Ensuring the Safe and Appropriate Use of Compounded Medications D-120.949
Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.
Citation: Sub. Res. 923, I-12; Reaffirmed: Res. 204, A-16; Reaffirmed in lieu of: Res. 817, I-16

Protect Individualized Compounding in Physicians' Offices as Practice of Medicine H-120.929
Our AMA will advocate that the US Food and Drug Administration remove physician offices and ambulatory surgery centers from its definition of a compounding facility.
Citation: Res. 219, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 518
(A-19)

Introduced by: American College of Cardiology

Subject: Chemical Variability in Pharmaceutical Products

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, It was revealed that certain lots of valsartan, losartan and irbesartan tablets contained trace amounts of N-Nitroso-dimethylamine (NDMA) and N-Nitrosodiethylamine (NDEA), which are classified as cancer causing substances; and

Whereas, The recalls resulting from identification of these pharmaceutical issues result in generalized recalls to patients as the lots/batches are not identifiable at the patient level; and

Whereas, The FDA has recently announced increasing the allowable nitrosamine contaminant level 100X for 6 months due to drug supply demands and the inability ensure an uncontaminated supply; and

Whereas, The FDA has recently announced the finding that specific lots of losartan/valsartan are contaminant free, emphasizing the importance and resolution of batch-level testing; and

Whereas, There are roughly 3 drug recalls per day, and roughly 100 recalls per year are associated with the risk of death; and

Whereas, A 2015 AMA study outlining factors leading to non-adherence identified mistrust and fear as significant factors leading to medication non-adherence, and a 2018 survey through Google consumer surveys identified mistrust in generics as being a major factor leading to medication non-adherence; and

Whereas, A 2015 FDA white paper reported the FDA has no formal means for quality surveillance, except through inspections; and inspection findings have not been a reliable predictor of the state of quality; and

Whereas, A 2010 Harvard Medical School Study showed lot-to-lot variability in anti-epileptic medications causes a 2.3X increased incidence of seizures; and

Whereas, Medication dissolution analysis has shown significant variability in dissolution from test state to physiological conditions, resulting in potentially clinically relevant differences in patient absorption; and

Whereas, The industry recognizes the importance of tracing lots which was enacted into law via the Drug Supply Chain Security Act of 2013, but the lots are not required to be connected to patients; and

Whereas, Private industry has started performing batch validation on pharmaceuticals which are documented, and traceable; and these pharmaceuticals are accessible to patients and other pharmaceutical distributors; therefore be it

RESOLVED, That our American Medical Association do a study and report back by the 2019 Interim Meeting regarding the pharmaceutical variability, both in active pharmaceutical ingredient and dissolution, the impact on patient care and make recommendations for action from their report findings (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislation requiring independent testing and verification of the chemical content of batches of pharmaceuticals (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the logging of batches at the patient level, so the batches can be traced and connected to patient outcomes or adverse events. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 519
(A-19)

Introduced by: Michigan

Subject: Childcare Availability for Persons Receiving Substance Use Disorder Treatment

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, In the United States in 2017, drug-related deaths exceeded 72,000, of which 49,068 were opioid-related, leading to 115 opioid overdose deaths per day, the highest figure in United States history, thus making opioids the leading cause of preventable death; and

Whereas, Opioid misuse has been associated with excess annual health care expenditures of up to $20,000 per person on private insurance and up to $15,000 for those on Medicaid, with the Centers for Disease Control and Prevention reporting the total economic burden of prescription opioid misuse in the United States as $78.5 billion per year; and

Whereas, The number of women dying from prescription opioid overdose increased 596 percent between 1999 and 2016 as compared to a 312 percent increase among men; and

Whereas, Women present with more severe medical, behavioral, psychological, and social problems upon treatment admission and progress more quickly from first drug use to regular use to treatment admission when compared to men; and

Whereas, Women are less likely to seek treatment for their substance use disorder than men, but gender does not affect treatment outcome once in treatment; and

Whereas, Many women do not seek treatment or drop out of treatment early because they are unable to take care of their children and, currently, less than four percent of substance use treatment facilities in the United States have beds for the children of admitted patients; and

Whereas, Evidence suggests family involvement in substance use treatment programming correlates with positive outcomes, substantiating the need for family services; and

Whereas, Longer treatment retention for patients in substance use rehabilitation programs correlates consistently with improved outcomes, and in a study of over 3,000 women being treated for substance use disorder, the ability to bring their children to treatment was a positive predictor for treatment retention in the rehabilitation program; and

Whereas, Limiting separation from the primary caregiver in the first year of life and continued family cohesion are believed to be protective factors against negative effects on children of parents with substance use disorder; and

Whereas, American Medical Association policies recognize that substance use disorders should be a major public health priority (H-95.975), endorse prompt access to treatment for chemically dependent patients (H-95.956), and encourage the expansion of opioid maintenance programs to any individual who applies and for whom the treatment is suitable, as driven by patient needs, medical judgment, and drug rehabilitation concerns (H-95.954); therefore be it

RESOLVED, That our American Medical Association support the implementation of childcare resources in existing substance use treatment facilities and acknowledge childcare infrastructure and support as a major priority in the development of new substance use programs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide

treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.
Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13

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.
Citation: (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13

Substance Use Disorders as a Public Health Hazard H-95.975
Our AMA:
(1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.
Citation: (Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 520
(A-19)

Introduced by: Michigan

Subject: Substance Use During Pregnancy

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, A 2012 national survey found that 5.9 percent of pregnant women used illicit drugs, 8.5 percent consumed alcohol and 15.9 percent smoked cigarettes; 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 tripled in 10 years due to increasing opiate using among pregnant women in Michigan and nationally; and

Whereas, Substance use during pregnancy is considered to be child abuse in 23 states and cases have been documented where women have been arrested despite voluntarily participating in substance use treatment programs, which is contrary to the American Medical Association's (AMA) stance on the issue (H-420.950); 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; and

Whereas, African American women and children have been shown to be disproportionately targeted and tested 1.5 times more often than non-black women and children for substance use, indicating that policies aimed at maternal substance use are being applied in a racially biased manner; and

Whereas, The Supreme Court has found that involuntary drug testing of pregnant women is a violation of the Fourth Amendment; 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" and that legally mandated testing and reporting threatens the physician-patient relationship, leading to disengagement from prenatal care; and

Whereas, The 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); 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; and

Whereas, Children who are removed from homes due to parental substance use are more likely to remain in foster care for longer, are moved between more placements, and are less likely to be reunited with their family, resulting in significant trauma; 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; therefore be it

RESOLVED, That our American Medical Association amend policy H-420.950, "Substance Use Disorders During Pregnancy," by addition and deletion as follows:

> 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~~.~~; and (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without an evaluation from a social worker. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: Res. 209, A-18

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.
Citation: BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18

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.
Citation: (Res. 131, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10

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.
Citation: 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

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.
Citation: (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 521
(A-19)

Introduced by: Michigan

Subject: Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, The Food and Drug Administration recently approved inhaled epinephrine (Primatene Mist HFA) as over-the-counter (OTC) treatment for patients with mild, intermittent asthma; and

Whereas, The use of inhaled epinephrine is not considered appropriate treatment for the management of asthma--regardless of the level of asthma severity; and

Whereas, Several expert panels have produced evidence-based recommendations on the treatment of asthma, and none recommend the use of inhaled epinephrine to treat asthma; and

Whereas, The National Asthma Education and Prevention Program (NAEPP), an expert panel convened by the National Institutes of Health, issued treatment guidelines for management of asthma and recommended against the use of epinephrine for treating asthma exacerbations; and

Whereas, Asthma is a serious respiratory condition that affects over 25 million Americans and even patients with mild or intermittent asthma can experience life-threatening asthma exacerbations; and

Whereas, Patients that view inhaled epinephrine as an “equivalent substitute” for more effective prescription drugs for asthma management will not have the benefit of more appropriate asthma medications that are proven to reduce asthma exacerbations, improve symptom control and have fewer side effects; and

Whereas, Without proper guidance, potential severe adverse outcomes are possible from unlimited access to inhaled epinephrine; and

Whereas, Placing inhaled epinephrine behind the counter will give pharmacists the opportunity to counsel patients on the risks and limitations of using inhaled epinephrine to treat asthma symptoms and, when appropriate, guide patients to primary care providers or appropriate specialist to prescribe patients safer and more effective medications; and

Whereas, The Food and Drug Administration does not have the authority to require an OTC drug be placed behind the counter; and

Whereas, Pharmacies have the discretion to hold these products behind the counter in the interests of patient health and safety; therefore be it

RESOLVED, That our American Medical Association work with national pharmacy chains to move inhaled epinephrine (Primatene Mist HFA) behind the counter. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Reference:
1. "The less beta2-selective agents (isoproterenol, metaproterenol, isoetharine, and epinephrine) are not recommended due to their potential for excessive cardiac stimulation, especially in high doses." National Asthma Education Prevention Program Expert Report 2 (1997) p. 64 figure 3-2.

RELEVANT AMA POLICY

Over-the-Counter Inhalers in Asthma H-115.972
Our AMA will send a letter to the US Food and Drug Administration (FDA) expressing: 1) our strong opposition to FDA making the decision to allow inhaled epinephrine to be sold as an over-the counter medication without first soliciting public input; and 2) our opposition to the approval of over-the-counter sale of inhaled epinephrine as it is currently not a recommended treatment for asthma.
Citation: CSA Rep. 2, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: Res. 927, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 522
(A-19)

Introduced by: Michigan

Subject: Improved Deferral Periods for Blood Donors

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Someone in the United States needs a blood product every two seconds, yet less than three percent of eligible donors will donate blood each year; and

Whereas, There are constantly blood supply shortages that deprive patients of lifesaving blood products; and

Whereas, American Medical Association (AMA) policy H-50.990, "Blood Shortage and Collection," calls for encouragement of blood donation to meet these increased demands and prevent shortage; and

Whereas, The current Food and Drug Administration (FDA) blood donation guidelines require a 12-month deferral period from the most recent sexual contact with a man who has had sex with another man (MSM); and

Whereas, 2.1 million potential MSM donors are unable to donate blood because of the 12-month deferral, and a reduced deferral period could potentially allow 317,000 more pints of blood to be collected each year; and

Whereas, Ninety percent of surveyed MSM individuals were interested in donating blood, yet only five percent reported that they would remain abstinent for an entire year to be eligible to donate; and

Whereas, Significant stigma still exists surrounding the 12-month deferral period in the MSM community, and it is essential to establish trust in the medical community by advocating for policy that is scientifically based; and

Whereas, No evidence supports the effectiveness of the current FDA 12-month deferral period, and a less stigmatized approach to blood donation criteria could simultaneously maintain the safety of the blood supply; and

Whereas, The Center for Disease Control and Prevention (CDC) claims nucleic acid testing (NAT) for HIV, the technology currently used by blood banks, is reliable to detect HIV within 10 to 33 days of exposure; and

Whereas, Results from mathematical modeling studies, and empirical data from Italy, the United Kingdom (UK), and Australia predict that altering Canada's MSM blood donation policy from a five- to a one-year deferral would not increase the number of transfusion-transmitted HIV infections; and

Whereas, Switching from a lifetime ban to a deferral period has a minute risk (one transfusion transmissible infection in 200 years) of increasing the number of HIV transmissions; and

Whereas, A review of current evidence for a deferral period before donation in Australia found that a 12-month deferral for gay and bisexual men exceeds what is required to maintain blood safety; and

Whereas, The UK changed their 12-month deferral to a three-month deferral in November 2017, reflective of a modeling study that predicted an increased risk of HIV positive donations after reducing the deferral to three months to be 0.18-0.67 per 1 million, which is within the acceptable threshold of one per million; and

Whereas, There are no cases of HIV transmission through plasma-derived products in the United States in the last 20 years; and

Whereas, Reducing the deferral period from 12 months would increase lifesaving blood donations, prevent blood shortages, and contribute to reducing harmful stigma experienced by the MSM community; and

Whereas, AMA policy H-50.973, "Blood Donor Deferral Criteria," does not specifically address the ability of updated, current HIV testing technology in its potential to decrease the deferral period for MSM; therefore be it

RESOLVED, That our American Medical Association amend AMA policy H-50.973, "Blood Donor Deferral Criteria," by addition and deletion to read as follows:

> Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on the scientific literature; ~~and~~ (3) supports a blood donation deferral period for men who have sex with men that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

References:
1. American Red Cross Blood Services. Blood Needs and Blood Supply.
2. Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products - Questions and Answers.
3. Pathogen inactivation and removal methods for plasma-derived clotting factor concentrates. Klamroth R, Gröner A, Simon TL. Transfusion. 2014 May;54(5):1406-17. Epub 2013 Sep 30.
4. The beliefs and willingness of men who have sex with men to comply with a one-year blood donation deferral policy: a cross-sectional study. Walter Liszewski, Christopher Terndrup, Nicole R. Jackson, Sarah Helland, Bridget C. Lavin. Transfusion. 05 July 2017.
5. Saving lives, maintaining safety, and science-based policy: qualitative interview findings from the Blood Donation Rules Opinion Study (Blood DROPS) for the NHLBI Recipient Epidemiology and Donor Evaluation Study-III (REDS-III). Shana Hughes, Nicolas Sheon, Bob Siedle-Khan Brian Custer. Transfusion. 14 August 2015.
6. Rethinking the Ban — The U.S. Blood Supply and Men Who Have Sex with Men. Sacks, Chana A; Goldstein, Robert H; Walensky, Rochelle P. The New England Journal of Medicine; Boston. Vol. 376, Iss. 2, (Jan 12, 2017): 174-177.
7. Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products. Guidance for Industry. U.S. Department of Health and Human Services Food and Drug Administration Center for Biologics Evaluation and Research December 2015.
8. Centers for Disease Control and Prevention. HIV/AIDS. October 31, 2018.
9. American Red Cross Blood Services. Infectious Disease Testing.

10. Jubran, Bellal, et al. "Reevaluating Canada's Policy for Blood Donations from Men Who have Sex with Men (MSM)." Journal of public health policy 37.4 (2016): 428-39. ProQuest. Web. 1 Jan. 2019.
11. Cahill, Sean, and Timothy Wang. "An End to Lifetime Blood Donation Ban in Israel for MSM would be a Major Step Toward a Science-Based Policy that Reduces Stigma." Israel Journal of Health Policy Research 6 (2017)ProQuest. Web. 1 Jan. 2019.
12. Blood donor deferral for men who have sex with men: still room to move. Haire B, Whitford K, Kaldor JM.Transfusion. 2018 Mar;58(3):816-822.
13. Update: Effects of Lifting Blood Donation Bans on Men who Have Sex with Men. Miyashita, Ayako. Gates, Gary. The Williams Institute. September 2014.
14. What is the evidence for the change in the blood ¬donation deferral period for high-risk groups and does it go far enough? Beattie RH Sturrock, Stuart Mucklow. Clin Med (Lond). 2018 Aug; 18(4): 304–307.

RELEVANT AMA POLICY

Blood Donor Deferral Criteria H-50.973
Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on the scientific literature; and (3) supports research into individual risk assessment criteria for blood donation. Citation: Res. 514, A-13; Modified: Res. 008, I-16

Safety of Blood Donations and Transfusions H-50.975
Our AMA:
(1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion;
(2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS;
(3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and
(4) Supports providing educational information to physicians on alternatives to transfusion. Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13

Blood Donor Recruitment D-50.998
1. Our AMA shall encourage the Food and Drug Administration to continue evaluating and monitoring regulations on blood donation and to consider modifications to the current exclusion policies if sufficient scientific evidence supports such changes.
2. Our AMA encourages the U.S. Food and Drug Administration to engage in dialogue with the American Association of Blood Banks and relevant stakeholders to reanalyze their therapeutic phlebotomy policies on variances, including but not limited to hereditary hemochromatosis. Citation: Sub. Res. 401, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 924, I-18

Blood Shortage and Collection H-50.990
In response to a continuing need for blood for transfusion and decreasing supplies of allogeneic blood, our AMA supports programs that encourage donation of blood to the allogeneic supply by health volunteer donors; and the AMA encourages physicians to participate in promotional efforts to encourage blood donation, and urges the American Blood Commission to actively participate in these programs. Citation: Res. 41, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified by CSA Rep. 11, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Voluntary Donations of Blood and Blood Banking H-50.995
Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply;
(2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science;
(3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and
(4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. Citation: (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 523
(A-19)

Introduced by: Michigan

Subject: Availability and Use of Low Starting Opioid Doses

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Our country faces a crisis of opioid dependency, causing 48,000 deaths annually with the number rising year-to-year, also contributing to disability, other health problems, and social breakdown; and

Whereas, Most opioid dependency begins with medically prescribed opioid treatment, with two-six percent of single opioid prescriptions leading to opioid dependency (per Centers for Disease Control and Prevention); and

Whereas, Most initial opioid prescriptions are for hydrocodone 5 mg or oxycodone 5 mg, usually in combination with acetaminophen; and

Whereas, 5 mg hydrocodone and 5 mg oxycodone are fairly strong medications, causing side effects in many, and these are sufficient doses to reinforce abuse in many; and

Whereas, Products consisting of hydrocodone 2.5 mg or oxycodone 2.5 mg in combination with acetaminophen are produced by multiple vendors, but not carried in many pharmacies and, where available, are often sold at substantially higher out-of-pocket price than products with hydrocodone 5 mg or oxycodone 5 mg; therefore be it

RESOLVED, That our American Medical Association reaffirm AMA Policies D-160.981, "Promotion of Better Pain Care," D-120.947, "A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief," D-120.976, "Pain Management," and D-120.971, "Promoting Pain Relief and Preventing Abuse of Controlled Substances," to ensure the dissemination of educational materials for physicians on options for prescribing the lowest effective dosage, such as hydrocodone 2.5 mg or oxycodone 2.5 mg with acetaminophen, for patients who need an initial prescription for an oral narcotic and work with pharmacies and other relevant stakeholders to ensure lower dosage options are stocked and available at prices that do not exceed that of the same narcotic at a higher dosage. (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

RELEVANT AMA POLICY

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; 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. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA 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. Our AMA 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.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief D-120.947
1. Our AMA will consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.
2. Our AMA will urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents.
3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities and in the care of patients with cancer and cancer-related pain, in much the same way as is being done for hospice and palliative care.
Citation: BOT Rep. 3, I-13; Appended: Res. 522, A-16; Modified: Res. 918, I-16; Reaffirmed in lieu of: Res. 803, I-16

Pain Management D-120.976
Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).
Citation: Res. 809, I-04; Appended: CSAPH Rep. 5, A-06; Appended: CSAPH Rep. 5, A-10; Reaffirmed in lieu of Res. 518, A-12

Promoting Pain Relief and Preventing Abuse of Controlled Substances D-120.971
Our AMA will:
(1) urge the Drug Enforcement Administration (DEA) to publicly restate their commitment to balance in promoting pain relief and preventing abuse of pain medications;
(2) support an ongoing constructive dialogue among the DEA and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion;
(3) strongly urge that the DEA's upcoming recitation of the pertinent legal principles relating to the dispensing of controlled substances for the treatment of pain maintain a patient-centered focus, including reaffirmation of its previous interpretation of law to permit practitioners to issue a series of prescriptions marked "do not fill" until a later date; and
(4) strongly urge that the DEA should promulgate, in consultation with relevant medical specialty societies and patient advocacy groups, a rational and realistic set of FAQs to assist in providing education to health care practitioners and law enforcement and regulatory personnel about appropriate pain management, and measures to be taken to minimize drug abuse and diversion.
Citation: BOT Rep. 3, A-06; Reaffirmation A-13; Reaffirmed: BOT Rep. 19, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-19)

Introduced by: Michigan

Subject: Availability of Naloxone Boxes

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, In the United States 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 United States history; and

Whereas, Opioid misuse has been associated with excess annual health care expenditures of up to $20,000 per person on private insurance and up to $15,000 for those on Medicaid with the Centers for Disease Control and Prevention reporting the total economic burden of prescription opioid misuse in the United States is $78.5 billion; 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; and

Whereas, Naloxone boxes are a bystander friendly kit designed to accommodate four doses of Naloxone, one rescue breaths mask, and an information card on accessing addiction treatment; 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; 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 percent did so correctly; and

Whereas, The community placement of naloxone boxes is analogous to the widespread distribution of automated external defibrillators (AEDs) in public spaces; 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 to use AEDs, administering AED programs managed by the American Heart Association, maintaining AEDs, and reporting AED use; 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; 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; 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 continue to have restrictions of accessibility and some still require a prescription to obtain the medication; and

Whereas, There are currently 36 states where possession of naloxone without a prescription may be considered a criminal offense and 15 states where naloxone dispensers do not have immunity from criminal prosecution for prescribing, dispensing or distributing naloxone to a layperson; 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; therefore be it

RESOLVED, That our American Medical Association support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription (New HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows:

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 organizations, 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~~ supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

References:
1. National Institute on Drug Abuse (NIDA). Overdose Death Rates.; 2018. https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates. Accessed September 1, 2018.
2. CDC/NCHS, National Vital Statistics System, Mortality. CDC Wonder, Atlanta, GA: US Department of Health and Human Services, CDC; 2017. https://wonder.cdc.gov.
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RELEVANT AMA 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.
Res. 225, A-14

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).
Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18

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.
Citation: 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; Reaffirmed: Res. 235, I-18

Improvement in US Airlines Aircraft Emergency Kits H-45.981
1. Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft.
2. Our AMA will: (a) support the addition of naloxone to the airline medical kit; (b) encourage airlines to voluntarily include naloxone in their airline medical kits; and (c) encourage the addition of naloxone to the emergency medical kits of all US airlines (14CFR Appendix A to Part 121 - First Aid Kits and Emergency Medical Kits).
Citation: Res. 507, A-97; Amended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of: Res. 502, A-16; Appended: Res. 524, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 525
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee E
(Leslie H. Secrest, MD, 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) and non-pharmacologic care (swaddling, frequent feeds, and skin-to-skin care), with most patients being admitted to a neonatal intensive care unit (NICU) [3]; 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 with a mean length of stay (LOS) in the NICU of 16.57 days, occupying 4% of US NICU beds[5-6]; and

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

Whereas, The flashing lights and alarms in a NICU do not reflect the recommended environment for patients with NAS, and 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[8-9]; 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, and continue to receive treatment while rooming-in with their child[10-11]; and

Whereas, Rooming-in was found to be associated with a reduction of 20-60% in patients requiring pharmacological treatment, shortened LOS from 17 days to an average of 12 days,

and lowered cost by 75% without a significant difference in readmission rates or adverse in-hospital events[1,9,11,12]; and

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

Whereas, Bonding and attachment aided by the release of oxytocin during breastfeeding may protect the mother against addiction relapse and stress, and breastfeeding can prevent or reduce complications of NAS so infants demonstrate lower NAS scores, need less pharmacological treatment, and have a shorter LOS[13-15]; and

Whereas, Maximum parental presence (100%) was associated with a 9-day shorter LOS and 8 fewer days of infant opioid therapy as well as fewer days of infant opioid therapy and reduced mean NAS score after adjusting for breastfeeding[16]; 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[17]; therefore be it

RESOLVED, That our American Medical Association support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, through the implementation of rooming-in programs (New HOD Policy); and be it further

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

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: (Res. 131, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10

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.
Citation: 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

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. Citation: (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 526
(A-19)

Introduced by: Medical Student Section

Subject: Trauma-Informed Care Resources and Settings

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

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"[1-4]; and

Whereas, Over two-thirds of Americans are exposed to at least one traumatic event by the age of 16 and each additional traumatic event increases the risk of an adverse health outcome proportionally[1,3,5,6]; and

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

Whereas, Physicians and other health care providers can mitigate trauma-induced adverse health outcomes, such as chronic disease and risky health behaviors, by practicing trauma-informed care[1,3,6]; and

Whereas, Trauma-informed care is the recognition of trauma's impact on patients' lives, identification 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 trauma-informed care training tools[12,13,14,15]; and

Whereas, There also exist several evidence-based school-based trauma-informed care interventions that have been shown to be effective in addressing trauma, resulting in decreased trauma-related symptoms, reduced PTSD scores, improved grades, and drops in disciplinary office referrals and suspensions[16-23];and

Whereas, Despite this evidence, trauma-informed services within schools have only been implemented at the district and state level in seventeen states[23,24]; 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 additional settings or 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 American Medical Association recognize trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization (New HOD Policy); and be it further

RESOLVED, That our AMA support trauma-informed care in all settings, including but not limited to clinics, hospitals, and schools, by directing physicians and medical students to evidenced-based resources. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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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; 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.
Citation: (Res. 419, A-11

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.
Citation: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 527
(A-19)

Introduced by: Medical Student Section

Subject: Increasing the Availability of Bleeding Control Supplies

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Injury is the leading cause of death for people under the age of 44 in the United States and severe bleeding accounts for greater than 33 percent of prehospital trauma deaths[1,2]; 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 emergency medical services (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 this does not reflect that the standard for such kits was updated in 2015 to include more comprehensive 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, Trained bystanders should have immediate access to updated and appropriate bleeding control supplies, such as a tourniquet and hemostatic gauze, to be most effective in controlling life-threatening bleeding[3]; and

Whereas, Our AMA previously passed policy which supports the widespread placement of AEDs in schools and other public places (H-130.935, D 470.992); therefore be it

RESOLVED, That American Medical Association Policy H-130.935, "Support for Hemorrhage Control Training," be amended by addition to read as follows:

H-130.935 Support for Hemorrhage Control Training
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.
3. Our AMA supports the increased availability of bleeding control supplies in schools, places of employment, and public buildings. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA 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.
Citation: Res. 519, A-16

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.
Citation: Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18

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;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 528
(A-19)

Introduced by: Medical Student Section

Subject: Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Surveys indicate that the majority (95% of males and 75% of females) of individuals have at least some lifetime exposure to pornographic material[1]; and

Whereas, In 2017, the Problematic Pornography Consumption Scale (PPCS) was developed to distinguish between nonproblematic and problematic pornography use and in a study of 772 respondents using the PPCS, 3.6% of pornography users belonged to the at-risk group[2]; and

Whereas, Individuals suffering from problematic pornography use may have impaired daily functioning that includes, but is not limited to, hardship on romantic relationships and job loss due to the inability to control urges to view pornography at work[3]; and

Whereas, The Kinsey Institute survey found that 9% of porn viewers reported that they had tried unsuccessfully to stop[3]; and

Whereas, There is emerging evidence that in these individuals, the meso-limbic-frontal regions of the brain that are associated with reward pathways are active and that there is dopaminergic and serotinergic neurotransmitter dysregulation similar to that of addictive disorders[4,5]; and

Whereas, A number of studies have linked problematic pornography use to increased incidence of erectile dysfunction[6] and higher rates of domestic violence[7-9]; and

Whereas, During the drafting of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2012, it was proposed that the addictive disorders category develop a new diagnosis called hypersexual disorder with a pornography subtype, but reviewers determined that there was not yet enough evidence to include the diagnosis in the 2013 publication[1]; and

Whereas, While AMA policy supports protecting youth from viewing pornography (H-60.934) and creating awareness about victims of child pornography and abuse (H-60.990),the AMA has no policy pertaining to adult pornography use or potential misuse; therefore be it

RESOLVED, That our American Medical Association support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

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RELEVANT AMA POLICY

Child Pornography H-60.990

Our AMA: (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; and (5) supports efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations.
Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Appended: Res. 913, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 529
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, When a federal agency writes a regulation, there is typically a 30-day minimum effective date for rules, 60-day minimum for major rules, and no minimum for good cause[1-3]; and

Whereas, Any US agency may delay or withdraw a rule before it becomes effective, and 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[4-6]; and

Whereas, The AMA makes an effort to monitor the proposal, adoption, and implementation of new rules and regulations, and has previously responded to delayed regulations that affect public health based on its robust existing policy on public health; and

Whereas, 72 public health regulations that were delayed after the Trump Administration took office were examined, and 14 of these regulations were identified as within the scope of the AMA: of these, 11 were considered standard 60-day delays, reasonably justified delays to obtain public comments, and/or the public health risk was deemed low; and

Whereas, Three of these delayed regulations were considered “most pressing” based on both significant negative public health impacts and high relevance based on existing AMA policy; and

Whereas, All three regulations identified as “most pressing” fell under the jurisdiction of the Environmental Protection Agency (EPA), illustrating that environmental regulations can pose a great burden to public health at large; and

Whereas, The negative public health impacts of the three delayed rules included but were not limited to: the release of toxic chemicals into the environment leading to harms to health; significant air pollution secondary to emissions from landfills and solid-waste facilities; and exposure to toxic pesticides that have documented adverse impacts on health across all ages; and

Whereas, The AMA has significant existing policy which compels AMA advocacy and action on toxic exposure (H-135.942, H-135.922), air pollution (H-135.991, H-135.950), and general environmental contributors to disease (D-135.997), and environmental stewardship (H-135.973); and

Whereas, These three rule delays have been met with opposition from multiple stakeholders, and could benefit from the AMA’s advocacy for vulnerable populations who are disproportionately at risk of negative health consequences secondary to the delays; therefore be it

RESOLVED, That our American Medical Association urge the Environmental Protection Agency 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA analyze ongoing regulation delays that impact public health, as deemed appropriate. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

References:
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RELEVANT AMA POLICY

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.
Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14

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.
Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11

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.
Citation: Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16

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.
Citation: Res. 914, I-17

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.
Citation: Res. 924, I-16

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

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

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.
Res. 402, A-03 Appended: Res. 927, I-11

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.
Citation: Res. 221, A-16

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.
Citation: (Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11

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.
Citation: (Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10

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.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 530
(A-19)

Introduced by: New Jersey

Subject: Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program

Referred to: Reference Committee E
(Leslie H. Secrest, MD, 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 American Medical Association collaborate with the Occupational Safety and Health Administration and state medical societies to include naloxone rescue kits in first aid equipment. (Directive to Take Action)

Fiscal Note: Not yet determined
Received: 05/09/19

References:

1. Opioid Overdose Crisis; National Institute on Drug Abuse. National Institute of Health, Mar. 2018, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis.
2. Schiller EY, Mechanic OJ. Opioid, Overdose. [Updated 2018 Apr 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2018 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK470415/
3. Boyer, Edward W. "Management of Opioid Analgesic Overdose." The New England journal of medicine 367.2 (2012): 146-155. PMC. Web. 24 Sept. 2018.
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6. Jack HE, Warren KE, Sundaram etc;."Making Naloxone Rescue Part of Basic Life Support Training for Medical Students." Academy of Emergency Medicine; 2018 Mar 30; 174-177
7. Berland N, Fox A, et al; Opioid overdose prevention training with naloxone, an adjunct to basic life support training for first-year medical students; Substance Abuse; 2017. Apr-Jun; 38(2): 123-128.
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10. Winstanley, Erin L. et al. "Barriers to Implementation of Opioid Overdose Prevention Programs in Ohio." Substance abuse 37.1 (2016): 42-46. PMC. Web. 24 Sept. 2018.
11. Gabay, Michael. "Increasing Access to Naloxone and Legal Issues." Hospital Pharmacy 51.8 (2016): 633-634. PMC. Web. 24 Sept. 2018.
12. New Jersey Opioid Summary; National Institute on Drug Abuse. National Institute of Health, April. 2019, https://www.drugabuse.gov/opioid-summaries-by-state/new-jersey-opioid-summary

NJ Legislation:
A-542/S-1830: Requires certain schools to maintain supply of opioid antidotes and permits emergency administration of opioid antidote by school nurse or trained employee.

RELEVANT AMA POLICY

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.
Citation: 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; Reaffirmed: Res. 235, I-18

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3.Our AMA 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.
Citation: Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15; Appended: Res. 311, A-18

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; 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. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA 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. Our AMA 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.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

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
Citation: CME Rep. 11, A-09; Reaffirmed: CME Rep. 03, I-18

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).
Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18

Reference Committee F

BOT Report(s)

01 Annual Report
04 AMA 2020 Dues
10 Conduct at AMA Meetings and Events
12 Data Used to Apportion Delegates
24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion
27 Advancing Gender Equity in Medicine

HOD Comm on Compensation of the Officers

01# Report of the House of Delegates Committee on Compensation of the Officers

Resolution(s)

601 AMA Policy Statement with Editorials
602 Expectations for Behavior at House of Delegates Meetings
603 Creation of an AMA Election Reform Committee
604 Engage and Collaborate with The Joint Commission
605 State Societies and the AMA Litigation Center
606 Investigation into Residents, Fellows and Physician Unions
607 Re-establishment of National Guideline Clearinghouse
608 Financial Protections for Doctors in Training
609 Update to AMA Policy H-525.998, "Women in Organized Medicine"
610 Mitigating Gender Bias in Medical Research
611# Election Reform
612# Request to AMA for Training in Health Policy and Health Law
613# Language Proficiency Data of Physicians in the AMA Masterfile
614# Racial and Ethnic Identity Demographic Collection by the AMA
615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership
616# TIME'S UP Healthcare
617# Disabled Physician Advocacy

Contained in the Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-19

Subject: Annual Report

Presented by: Jack Resneck, Jr. MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

The Consolidated Financial Statements for the years ended December 31, 2018 and 2017 and the Independent Auditor's report have been included in a separate booklet, titled "2018 Annual Report." This booklet is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-A-19

Subject: AMA 2020 Dues

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Our American Medical Association (AMA) last raised its dues in 1994. AMA continues to invest in improving the value of membership. As our AMA's membership benefits portfolio is modified and enhanced, management will continuously evaluate dues pricing to ensure optimization of the membership value proposition.

RECOMMENDATION

2020 Membership Year

The Board of Trustees recommends no change to the dues levels for 2020, that the following be adopted and that the remainder of this report be filed:

Regular Members	$ 420
Physicians in Their Second Year of Practice	$ 315
Physicians in Military Service	$ 280
Physicians in Their First Year of Practice	$ 210
Semi-Retired Physicians	$ 210
Fully Retired Physicians	$ 84
Physicians in Residency Training	$ 45
Medical Students	$ 20

(Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-19

Subject:	Conduct at AMA Meetings and Events
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee F (Greg Tarasidis, MD, Chair)

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-140.954, "Harassment Issues Within the AMA," which provided:

> That our American Medical Association immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or both with report back regarding said processes and implementation at the 2019 Annual Meeting. (Directive to Take Action)

In furtherance of Policy D-140.954, the AMA immediately engaged two outside consultants, Amy L. Bess, Esq. of Vedder Price PC and Sherry Marts of S*Marts Consulting, to review, evaluate and provide recommendations as to the AMA Policy H-140.837, "Anti-Harassment Policy," including the investigative and disciplinary processes thereunder, as previously adopted by the House of Delegates (see Appendix A for the consultants' professional biographies). This report of the Board of Trustees summarizes the evaluation and joint recommendations provided by the consultants and recommends revisions to the procedures implementing the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities. The Board of Trustees believes that these recommendations will result in significant improvements to help ensure that AMA meetings are safe, welcoming and free of inappropriate conduct.

BACKGROUND

At the 2017 Annual Meeting, the AMA House of Delegates adopted Policy H-140.837, "Anti-Harassment Policy." The policy communicates the AMA's commitment to zero tolerance for harassing conduct at or in conjunction with AMA-sponsored meetings and events, and provides a clear definition of what constitutes harassing conduct (see Appendix B for full text). The policy was proffered by Board of Trustees Report 23-A-17, which provided that:

> Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

At the 2018 Annual Meeting, the Board of Trustees presented Board of Trustees Report 20-A-18, which recommended procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards. Such recommended procedures included:

- Mechanisms by which any persons who believe they have experienced or witnessed conduct in the AMA House of Delegates or in other meetings and activities hosted by the AMA (e.g., meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards) in violation of Anti-Harassment Policy H-140.837 could promptly notify the presiding officer(s) of such AMA meeting or activity, the Chair of the Board and/or the AMA Office of General Counsel, or report such violation by means of a telephonic or online hotline (with the option to report anonymously).
- Prompt and thorough investigation of harassment complaints to be conducted by AMA Human Resources, with AMA Human Resources responsible for making determinations as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.
- The establishment of a three-member disciplinary committee comprised of the Chair of the Board of Trustees, the Immediate Past President of the AMA and the President-Elect of the AMA, to which violations of Anti-Harassment Policy H-140.837 would be referred for disciplinary and/or corrective action, including but not limited to expulsion from the relevant AMA meetings or activities and/or referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action.

At the 2018 Annual Meeting, following extensive testimony concerning the recommended procedures set forth in Board of Trustees Report 20-A-18, the AMA House of Delegates adopted *with amendment* the recommendations of the Board of Trustees as to disciplinary action. In particular, the House of Delegates modified the recommendations of the Board of Trustees whereby all violations of Anti-Harassment Policy H-140.837 would be referred immediately to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary action, rather than to the three-member disciplinary committee recommended by the Board of Trustees, as follows:

> If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA -associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.
>
> If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.
>
> If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

At the 2018 Interim Meeting, CEJA presented Council on Ethical and Judicial Affairs Report 4-I-18, "CEJA Role in Implementing H-140.937, 'Anti-Harassment Policy,'" expressing concerns about the scope of responsibilities delegated to CEJA under Anti-Harassment Policy H-140.837(3),

Disciplinary Action, as modified and adopted by the House of Delegates at the 2018 Annual Meeting, and requesting that Policy H-140.837(3), Disciplinary Action, be reconsidered. The House of Delegates did not accept CEJA's recommendation, but did adopt Policy D-140.954, as noted above.

DISCUSSION

In furtherance of Policy D-140.954, two external consultants with substantial expertise in this area were immediately engaged. The purpose of engaging two separate consultants was to ensure that legal and operational points of view were both considered, and that any recommendations would reflect a common view of best practice, rather than a single evaluation. The consultants reviewed and evaluated Policy H-140.837, "Anti-Harassment Policy," and compared it to current best practices as well as policies and procedures currently in use by other membership societies. The consultants' review considered the policy in two parts – i) the anti-harassment policy itself, and ii) the procedures to implement the policy.

The consultants observed that the AMA's existing anti-harassment policy includes the critical elements of an effective policy (the first of the two parts mentioned above): a clear definition of unacceptable conduct; a clear statement of when, where, and to whom the policy applies; a statement that retaliation for reporting violations of the policy is itself a violation of the policy; and a statement that reports of violations will be kept confidential to the extent possible. Thus, the consultants were complimentary of this first portion of the policy, and recommended only modest changes (see "*Consultants' recommendations for revision of the policy,"* below). However, the consultants noted that the current policy also includes material that more properly belongs in a detailed "enforcement procedures" document, and that the implementation procedures described in the existing policy (the second of the two parts mentioned above) do not entirely reflect current best practices. The consultants therefore recommended more substantive revisions to these procedural aspects of the policy (see "*Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines,"* below.)

Below are the consultants' specific observations and joint recommendations.

Consultants' recommendations for revision of the policy

The consultants recommend that the name of the policy be changed to "Policy on Conduct at AMA Meetings and Events." The reasons for this recommendation are:

- It more accurately captures a comprehensive objective to promote respectful, professional, and collegial behavior at AMA meetings and events and to effectively address violations of the policy.
- It avoids confusion as to what the policy covers. Most people equate "anti-harassment" policies or trainings with anti-*sexual* harassment. Although this policy addresses sexual harassment, it is much broader in scope and includes a prohibition of harassment on the basis of characteristics other than sex or gender.

The consultants recommend that the current policy be retained, with the following additions:

- A statement that the purpose of the policy is to protect participants in AMA activities from harm
- A description of desired behavior in interactions, for example:
  - Exhibit professional, collegial behavior at all times

  - Exercise consideration and respect in your speech and actions, including while making formal presentations to attendees
  - Be mindful of one's surroundings and of fellow participants
  - Alert meeting Chair or meeting organizer of violations of the anti-harassment policy – even if they seem inconsequential
- A statement about potential consequences for violation of the policy. For example: If a participant engages in unacceptable behavior at an AMA meeting or event, AMA reserves the right to take any action deemed appropriate based on the outcome of the incident investigation(s). This action may include but is not limited to:
  - Removing the violator from the AMA event or activity, without warning or refund;
  - Prohibiting the violator from attending future AMA events or activities;
  - Removing the violator from leadership or other roles in AMA activities;
  - Prohibiting the violator from assuming a future leadership or other role in AMA activities;
  - Revoking the violator's membership in the AMA, following the CEJA processes for taking such an action;
  - Notifying the violator's employer of the actions taken by AMA; and/or
  - Notifying law enforcement.

The consultants recommend the implementation of processes and tactics to help ensure that attendees of AMA meetings and events are made aware of the policy and consequences for violations of the policy, and mechanisms by which attendees affirmatively acknowledge and assent to the policy.

The consultants recommend that the sections of the policy beginning with "1. Reporting a complaint of harassment" through "3. Disciplinary Action" be replaced with Operational Guidelines as described below.

Consultant recommendations for changes to implementation and enforcement of the policy – Operational Guidelines

The current policy includes detailed procedures for reporting, investigation, and enforcement of the policy. However, the procedures described in the policy do not entirely reflect current best practices in implementation and enforcement of such a policy. In addition, implementation of these procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming to all participants.

Current best practices for implementation and enforcement include:

1. Ensuring awareness, acknowledgement and acceptance of the policy by meeting/event participants
2. Simple and straightforward ways to report violations of the policy at the time of (or very close in time to) the incident in question.
3. Independence and neutrality in investigation of violations of the policy.
4. Avoidance of even the appearance of conflicts of interest in decisions on consequences for violations of the policy.
5. Assurance that all reports of violation and the outcomes of investigations will be reported to the organization's counsel.
6. Assurance that reports, investigations, and outcomes will be kept confidential to the fullest extent possible, consistent with usual business practices.

The consultants further recommend that the policy be amended to reflect the need for flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences. This flexibility is necessary because of the wide range of meetings and activities covered by the policy, including consideration of the purpose, size and duration of meetings and activities.

Specifically, the consultants recommend adoption of the following operational guidelines for reporting, investigation, and enforcement of the policy.

Violation Reporting Procedures

In order to encourage individuals who are targets of harassment to report incidents, it is important to have a simple, straightforward, and easily publicized reporting mechanism. Ideally, reports should be taken and investigated by a single individual who is unlikely to face conflicts of interest in this role.

The consultants recommend that the AMA bring in an independent consultant to act as the Conduct Liaison for larger meetings and events. This should be someone who is trained and experienced in handling incidents of harassment and bullying. The Conduct Liaison should be the primary point of contact for event participants to report violations of the policy, and responsible for any on-site investigations of those violations. The Conduct Liaison should provide recommendations for immediate action to the Event Chair or other senior designated AMA officer or representative involved in the AMA meeting in question, and should provide a formal report with recommendations for any further action to the Committee on Conduct at AMA Meetings and Events (CCAM, see below). All reported violations of the policy, and the outcomes of investigations by the Conduct Liaison, should be provided to the Office of General Counsel.

For smaller meetings, the role of the Conduct Liaison may be assumed by an individual designated by the AMA Office of General Counsel and trained in advance of assuming such role, who may or may not be physically on-site at the meeting. If not on-site, the Conduct Liaison should be on-call.

The consultants recommend retaining the requirement for a reporting hotline in addition to the Conduct Liaison, which will be an alternative source for meeting attendees to lodge complaints regarding conduct at meetings.

Investigation of Incidents

Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event in order to provide recommendations for action to the CCAM.

Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Committee on Conduct at AMA Meetings and Events (CCAM)

The consultants recommend the establishment of a Committee on Conduct at AMA Meetings and Events (CCAM), to include 5-7 members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The consultants recommend that the CCAM should include one member of the

Women Physicians Section (WPS), and one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally. Emphasis should be placed on maximizing the diversity of membership.

The consultants recommend that the CCAM receive reports on all violations of the policy arising from any AMA meeting or event. When an incident is significant enough that it requires action beyond those taken on-site at the event, the CCAM reviews the incident reports, performs further investigation if needed, and makes recommendations regarding further commensurate sanctions to the Office of General Counsel and to the appropriate AMA body (e.g., meeting or event organizers, appropriate AMA staff, and/or CEJA).

To prevent possible retaliatory action against CCAM members, all proceedings of the CCAM should be kept as confidential as practicable.

CONCLUSION

As noted above, consultants engaged by the AMA in furtherance of Policy D-140.954 have reviewed and evaluated the AMA's current Anti-Harassment Policy (Policy H-140.837) and confirmed that this existing policy includes many of the critical elements of an effective anti-harassment policy. However, while the current policy includes detailed procedures for reporting, investigation, and enforcement, several amendments to the policy are necessary to bring it fully in line with current best practices in implementation and enforcement. The consultants suggested that implementation of the existing procedures would be cumbersome and unlikely to bring about the desired outcome of making AMA meetings and events safer and more welcoming.

The consultants have recommended modifications to ensure that the policy itself, and the procedures for reporting, investigation and enforcement of the policy, reflect current best practices. In particular, the consultants' recommended modifications are intended to ensure 1) simple ways to report violations, 2) prompt investigation and resolution of alleged violations, 3) independence and neutrality in investigation of violations, and the avoidance of conflicts of interest, and 4) flexibility in procedures for receiving reports, investigating incidents, and making decisions on consequences of the policy (recognizing the nature, number and varying size of AMA meetings conducted each year).

The Board of Trustees has carefully considered the recommendations of the consultants, and believes that these recommendations are consistent with the goals and objectives of the AMA's current Anti-Harassment Policy and will result in significant improvements to help ensure that AMA meetings and events are safe and welcoming to all participants. The Board of Trustees also believes that these recommendations are responsive to comments and concerns expressed at the 2018 Interim Meeting. Therefore, the Board of Trustees is recommending corresponding modifications to Policy H-140.837, "Anti-Harassment Policy," as set forth below.

RECOMMENDATION

The Board of Trustees recommends the following, and that the remainder of this report be filed:

1. That Policy D-140.954, "Harassment Issues Within the AMA," be rescinded as having been fulfilled by the report. (Rescind HOD Policy)

2. That Policy H-140.837, "Anti-Harassment Policy," be renamed "Policy on Conduct at AMA Meetings and Events" and further amended by insertion and deletion as follows (Modify Current HOD Policy):

~~Anti-Harassment Policy Applicable to AMA Entities~~
Policy on Conduct at AMA Meetings and Events

It is the **policy** of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

~~a~~Any type of harassment of any attendee of an AMA ~~staff, fellow delegates or others by members of the House of Delegates or~~ hosted meeting, event and other ~~attendees at or in connection with HOD meetings, or otherwise~~ activity, including but not limited to dinners, receptions and social gatherings held in conjunction with ~~HOD meetings,~~ an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA ~~delegates and staff are conducting AMA~~ business is conducted. This zero tolerance **policy** also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise ~~protected group status~~, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this **policy**, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and

- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any

AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. *Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)*

   The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

   The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. *Reporting Violations of the Policy*

   Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings

of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

~~1. Reporting a complaint of harassment~~

~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.~~

~~Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~

~~Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.~~

~~2. Investigations~~

~~Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.~~

~~3. Disciplinary Action~~

~~If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.~~

~~If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.~~

~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.~~

~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.~~

~~4. Confidentiality~~

~~To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.~~

Fiscal note: $75,000-$100,000 for Conduct Liaison fees and travel expenses, as well as potential meeting costs for the Committee on Conduct at AMA Meetings and Events.

APPENDIX A

Biographies

AMY L. BESS, J.D. has practiced in the area of employment defense for more than thirty years and currently serves as Chair of the global Labor and Employment practice group for Vedder Price and is a member of firm's Board of Directors.

Her employment litigation experience includes the representation of employers before U.S. state and federal courts and administrative agencies, defending against claims of race, sex, disability and age discrimination; sexual harassment; whistleblower retaliation; restrictive-covenant disputes; wrongful termination; and wage and hour violations. She regularly counsels clients in all of these areas, drafts and negotiates employment and severance agreements, conducts on-site workplace investigations, presents training seminars and speaks to employer groups on avoiding workplace problems. Ms. Bess is an author and frequent speaker on a variety of employment topics, most notably on the impact of the #MeToo movement and anti-harassment laws and best practices organizations should undertake to prevent and resolve harassment concerns. She is regularly quoted in the media on these and related topics.

Select Publications

"A Four-Part Series: Addressing Sexual Harassment in the #MeToo Era" ("Best Practices for Investigating Allegations", "The Rights of the Alleged Harasser", "The Superstar Harasser–Is Anyone Really Too Big to Lose?" and "The Same Old Workplace Training Won't Cut It") *Corporate Compliance Insights*, February 8, March 28, May 4 and June 21, 2018

"Oops, He (or She) Did It Again! Implementing a Best-In-Class Harassment-Free Workplace Program to Help Your Company Stay Out of the Headlines" *Employee Relations Law Journal*, Winter 2017

"Gender Identity Discrimination Claims on the Rise at State and Federal Levels" *The National Law Review*, March 3, 2016

Select Speaking Engagements

Conference Co-Chair/Moderator, "Employment Law Lessons Learned from Recent Scandals" PLI Employment Law Institute 2018, October 2018, New York, NY

"Vedder Talk: Lessons Learned from the #MeToo Movement" 2018 Vedder Works Employment Law Series, October 2018, Washington, D.C.

"Advising Clients on Sexual Harassment Law in the #MeToo Era" DC Bar, July 12, 2018

"Harassment in the Workplace, Part 2 - Community and Resources: Hearing Voices & Exploring Conversation Strategies" American Institute of Architects Conference on Architecture 2018, June 23, 2018, New York, NY

"Employee Relations in the #MeToo Era: Creating a Culture of Respect" 2018 Vedder Works Employment Law Series: April 24, Chicago, IL and June 1, Chicago–O'Hare, IL, June 14, New York, NY

"Sexual Harassment: Lessons Learned from Recent Scandals" PLI Sexual Harassment Webcast, November 2017

"Conducting and Documenting Investigations and Termination Actions" 2014 Vedder Price Employment Law Update: Rosemont, IL

SHERRY A. MARTS, PH.D., CEO of S*Marts Consulting LLC, is a former association CEO with a wide-ranging background in biomedical research, nonprofit management, public education, and research advocacy, Sherry provides expert consulting services to nonprofits and academic institutions on diversity and inclusion, harassment and bullying, and interpersonal communication. Her work includes a particular focus on harassment and bullying at professional society meetings and conferences. She provides training for society and association staff on how to implement and enforce meeting codes of conduct. She also leads workshops on active bystander intervention, harassment resistance, and ally skills. Her interest in the issue of harassment and bullying lies at the intersection of her professional life as a woman in science, and her previous experience as a women's self-defense instructor.

Sherry is the recipient of the 2018 MIT Media Lab Disobedience Award.

Select Publications

"Open Secrets and Missing Stairs: Sexual and Gender-Based Harassment at Scientific Meetings," available at http://bit.ly/osmspdf

"Include is a Verb: Moving from Talk to Action on Diversity and Inclusion," available at http://bit.ly/2peWwP0

"The Book of How: Answers to Life's Most Important Question."

Dr. Marts received her B.Sc. (Hons.) in Applied Biology from the University of Hertfordshire, and her Ph.D. in Physiology from Duke University.

APPENDIX B

AMA Policy H-140.837, "Anti-Harassment Policy"

1. Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.

Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each

complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA's Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-19

Subject: Data Used to Apportion Delegates

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

At the 2018 Interim Meeting, Policy G-600.016, "Data Used to Apportion Delegates G-600.016," was adopted. It states that:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each national medical specialty and state medical society of its current AMA membership count status report.

2. "Pending members" will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to national medical specialty and state medical societies for the following year.

3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous "pending members" at the end of the following year until their membership has been renewed.

Reporting mid-year membership counts to state medical societies as called for in paragraph 1 of the policy is a straightforward process and will be implemented within one month following the conclusion of the 2019 Annual Meeting of the House of Delegates. Because current Policy G-600.027 links the total number of national medical specialty society delegates to the overall number of constituent (i.e., state) association delegates and because membership counts for most national medical specialty societies are based on their most recent five-year review, membership figures will be unchanged from the apportionment data for all national medical specialty societies other than those that undergo a five-year review at the just concluded Annual Meeting. Accordingly, your Board of Trustees offers an alternate recommendation to clarify mid-year reporting.

The remainder of this report deals primarily with implementation of the second and third paragraphs of Policy G-600.016.

APPORTIONMENT OF DELEGATES

Under current AMA Bylaws (2.1.1), constituent associations are apportioned delegates at the rate of one delegate for each 1000 (or fraction thereof) **active** AMA members within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year. Thus, for example, a constituent association with 1000 or fewer AMA members is apportioned one delegate and one alternate delegate, while a constituent association with from 1,001 to 2,000 AMA members will receive two delegates and two alternate delegate seats. (Some other bylaws provisions deal with special circumstances such as a loss of AMA members by the constituent association, but

those are not relevant for purposes of this report.) For 2019, 281 delegates were apportioned to constituent associations, which in turn means that 281 delegates were apportioned to national medical specialty societies using methods specified in Policy G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates." For both constituent associations and national medical specialty societies membership figures are calculated as of December 31 and delegates are apportioned for the following year. While actual end-of-year counts are used for constituent associations, national medical specialty society data generally come from the most recent five-year review.

Apportionment Under Policy G-600.016

Although the plan described below was adopted by the House of Delegates at I-18, no changes in delegate apportionment are possible until the AMA Bylaws are amended. The figures in Appendix 1 for the (hypothetical) 2019 delegate apportionment to constituent associations are based on this plan. Because national specialty society delegate apportionment is hinged to constituent associations, national specialty societies are not included in the table.

The definition of "pending members" referenced in paragraph 2 of Policy G-600.016 is critical to understanding apportionment under the new policy. Board of Trustees Report 1-I-18, which eventuated in Policy G-600.016, defined pending members as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year. For example, a nonmember in 2018 who during calendar year 2018 completed an application and paid dues for the 2019 membership year would be a "pending member." In practical terms, a pending member's active membership is not in effect on December 31, only becoming active the next day. Under current rules, those members are not reported as members in any end-of-year statistics. Pending members typically acquire "pending" status in the fourth quarter of a given year. Under Policy G-600.016 "pending members" will be added to the active members as of December 31 to determine delegate allocation for the following year.

The figures in the two rightmost columns of Appendix 1 were calculated using this plan, which counts both active and pending members for purposes of delegate apportionment. This count will differ from the membership reported in the annual "Performance, Activities and Status" report (BOT Report 7 at this meeting).

As is apparent from Appendix 1, the inclusion of pending members will result in ten new delegates. Thereafter, the plan will have relatively few effects. This is so for two reasons. As noted, delegates are apportioned at the one per 1000 members rate, so for a constituent association to gain a delegate, the number of pending members must move its member count across a 1000 threshold. The likelihood of that for any given constituent society after the first year when a few societies that are close to the threshold see a positive effect is low. At the same time, the number of pending members must more than offset the number of active members who do not renew their memberships for the succeeding year to have an ongoing positive effect.

It is critical to avoid any gaming of the system. Consider a nonmember who becomes a pending member late in the year. As a pending member, that individual enters into the apportionment calculations for the succeeding year, and as a then current member would also be included in the counts for the next year as well. The following chart shows how someone joining late in the year every other year would affect delegate apportionment.

YEAR	MEMBERSHIP STATUS	DUES PAYMENT	COUNTED IN APPORTIONMENT
Year 1	Pending	Pays for year 2	Counts for year 2
Year 2	Member	Does not renew	Counts for year 3
Year 3	Pending	Pays for year 4	Counts for year 4
Year 4	Member	Does not renew	Counts for year 5
Year 5	Pending	Pays for year 6	Counts for year 6

Insofar as AMA membership benefits ought to accrue to members, and our members report that representation and advocacy on their behalf are highly valued, it is critical that apportionment be based on members, not individuals seeking to game the system. Paragraph 3 of Policy G-600.016 attempts to resolve the issue by calling for the development of a mechanism to prevent a second counting of these members the following year until they have renewed their membership. To ensure that a "pending member" who only pays membership for a single year is not counted for apportionment for two years, our AMA will track each "pending member" (who will be added to the membership count for purposes of delegate apportionment in the year in which they paid membership dues for the following year, as per paragraph 2) and, as specified in paragraph 3, they will not be counted in the subsequent year's apportionment unless they renew their membership before the end of the following year. Once a "pending member" has renewed their membership for the following year, going forward they will be counted like all other active members and will no longer be tracked. While your Board of Trustees recognizes that it is still possible to "game" this system, continued tracking of an increasing cohort of "pending members" presents an ever-increasing data burden.

Our AMA currently reports active membership for any given year and over the course of the calendar year for a variety of reasons. We do not currently track "pending members" and certainly do not follow these members prospectively. Implementation of Policy G-600.016 will require an internal process to perform tracking of these individual members. Because the impact upon our AMA and the constituent societies of the House of Delegates of this new apportionment methodology beyond the first year is unknown and the data challenges to track pending members as they renew for subsequent years are difficult to determine prospectively, your Board of Trustees recommends that Policy G-600.016 be amended to reflect a trial period with a report back on the impact and recommendations for the future be submitted to the House of Delegates at the 2022 Annual Meeting.

CONCLUSION

Your Board of Trustees has prepared this report to ensure clarity with respect to the yet to be implemented plan for delegate apportionment outlined in Policy G-600.016 and to afford members of the House of Delegates an opportunity to provide additional input via the reference committee process. Moreover, because apportionment is effective for a calendar year, Bylaws amendments at the upcoming Interim Meeting will allow timely execution of the policy.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and the remainder of the report be filed:

A. That Policy G-600.016, "Data Used to Apportion Delegates," be amended to read as follows:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review ~~and state medical society~~ of its current AMA membership count ~~status report~~. (New HOD Policy)

2. "Pending members" will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to ~~national medical specialty and~~ state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (New HOD Policy)

~~3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous "pending members" at the end of the following year until their membership has been renewed. (Directive to Take Action)~~

3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year. (New HOD Policy)

4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy. (Directive to Take Action)

B. That the Council on Constitution and Bylaws prepare a report for the 2019 Interim Meeting that will allow the implementation of Policy G-600.016, as amended herein.

Fiscal Note: $8,695

APPENDIX 1

Constituent Association Delegate Apportionment: 2019 Actual and 2019 Hypothetical

Constituent Association	AMA members as of 31 Dec 2018	Apportionment 2019	AMA members including pending members	2019 hypothetical apportionment
Total	**250,253**	**280**	**263,061**	**290**
Alabama	3,062	4	3,206	4
Alaska	352	1	367	1
Arizona	4,271	5	4,424	5
Arkansas	2,021	3	2,090	3
California	22,429	23	23,548	24
Colorado	4,096	5	4,206	5
Connecticut	3,413	4	3,601	4
Delaware	668	1	690	1
District of Columbia	1,981	2	2,085	3
Florida	13,489	14	14,142	15
Georgia	4,874	5	5,170	6
Guam	25	1	28	1
Hawaii	1,078	2	1,119	2
Idaho	563	1	595	1
Illinois	11,069	12	11,580	12
Indiana	4,439	5	4,924	5
Iowa	2,151	3	2,212	3
Kansas[1]	1,903	2	1,990	2
Kentucky	3,228	4	3,376	4
Louisiana	4,024	5	5,571	6
Maine	1,337	2	1,367	2
Maryland	4,414	5	4,658	5
Massachusetts	12,321	13	12,546	13
Michigan	12,011	13	12,467	13
Minnesota	4,393	5	4,586	5
Mississippi	2,749	3	2,830	3
Missouri	4,846	5	5,123	6
Montana	679	1	704	1
Nebraska	1,640	2	1,727	2
Nevada	1,471	2	1,530	2
New Hampshire	877	1	918	1
New Jersey	7,074	8	7,455	8
New Mexico	1,285	2	1,345	2
New York	19,468	20	20,529	21
North Carolina	5,181	6	5,471	6
North Dakota	762	1	776	1
Ohio	10,593	11	11,066	12
Oklahoma	3,751	4	3,813	4
Oregon	1,902	2	2,015	3
Pennsylvania	13,213	14	13,886	14
Puerto Rico	1,399	2	1,495	2
Rhode Island	1,018	2	1,072	2
South Carolina	4,572	5	4,694	5
South Dakota	963	1	997	1
Tennessee	4,744	5	4,943	5
Texas	18,002	19	18,735	19

Constituent Association	AMA members as of 31 Dec 2018	Apportionment 2019	AMA members including pending members	2019 hypothetical apportionment
Utah	1,668	2	1,760	2
Vermont	416	1	444	1
Virgin Islands	37	1	40	1
Virginia	7,111	8	7,360	8
Washington	3,888	4	4,087	5
West Virginia	1,831	2	1,944	2
Wisconsin	4,556	5	4,800	5
Wyoming	202	1	205	1
APO/FPO	743	-	749	-

1. Kansas had three delegates in 2018 and can retain the third delegate by submitting a plan for intensified membership recruitment. See bylaw 2.1.1.1.1.
2. Figures do not include delegates awarded under special bylaws provisions (e.g., provisions for the speaker and vice speaker).

APPENDIX 2

Current AMA Policy and Bylaws

Policy G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates"

1. Specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process:
   (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof.
      (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.
   (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.
      (i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.
      (ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.
      (iii) In the case of a tie, the previous year's data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.

3. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

Bylaw B-2.1, "Constituent Associations"

Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association

from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates.

2.1.1 Apportionment. The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year.

2.1.1.1 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.1.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

2.1.1.2 Unified Membership. A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment during the first 2 years in which the unified membership bylaw provisions are implemented.

2.1.2 Additional Delegates. A constituent association meeting the following criteria shall be entitled to the specified number of additional delegates.

2.1.2.1 Unified Membership. A constituent association shall be entitled to 2 additional delegates if all of its members are also members of the AMA. If during any calendar year a constituent association adopts bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the constituent association shall be entitled to the 2 additional delegates. The constituent association shall retain the 2 additional delegates only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that all of the constituent association’s members are members of the AMA.

2.1.2.2 Minimum 75% Membership. A constituent association shall be entitled to one additional delegate if 75% or more of its members, but not all of its members, are members of the AMA. The constituent association shall retain the additional delegate only if the membership information as recorded by the AMA as of each subsequent December 31 confirms that 75% or more of the constituent association’s members are members of the AMA. If the membership information indicates that less than 75% of the constituent association’s members are members of the AMA, the constituent association shall be permitted to retain the additional delegate for one additional year if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. If the membership information for the constituent association, as recorded by the AMA as of the following December 31 indicates that for the second successive year less than 75% of the constituent association’s members are members of the AMA, the constituent association shall not be entitled to retain the additional delegate.

2.1.2.3 Maximum Additional Delegates. No constituent association shall be entitled to more than 2 additional delegates under Bylaw 2.1.2.

2.1.2.3.1 Effective Date. The additional delegates provided for under this bylaw shall be based upon membership information recorded by the AMA as of December 31 of each year. Allocation of these seats shall take effect on January 1 of the following year.

2.1.3 Selection. Each constituent association shall select and adjust the number of delegates to conform with the number of seats authorized under this bylaw.

2.1.4 Certification. The president or secretary of each constituent association shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates.

2.1.5 Term. Delegates from constituent associations shall be selected for 2-year terms and assume office on the date set by the constituent association, provided that such seats are authorized pursuant to these Bylaws. Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. One-year terms may be provided but only to the extent and for such time as is necessary to accomplish this proportion.

2.1.6 Vacancies. The delegate selected to fill a vacancy shall assume office immediately after selection and serve for the remainder of that term.

2.1.7 Resident/Fellow Physician and Medical Student Delegates. A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a resident/fellow physician member or a medical student member.

2.1.7.1 Term. Such resident/fellow physician or medical student delegate or alternate delegate shall serve for a one-year term beginning as of the date of certification of the delegate or alternate delegate by the constituent association to the AMA.

2.1.7.2 No Restriction on Selection. Nothing in this bylaw shall preclude a resident/fellow physician or medical student member from being selected to fill a full 2-year term as a delegate or alternate delegate from a constituent association as provided in Bylaw 2.1.5.

2.1.8 Application by a Constituent Association for Representation in the House of Delegates. A constituent association seeking representation in the House of Delegates shall submit an application to the AMA. The Board of Trustees shall make a recommendation to the House of Delegates as to the proposed constituent association’s qualifications for representation, based on all the current guidelines for representation in the House of Delegates.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-19

Subject: Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion (Resolution 607-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 607, "Discounted/ Waived CPT Fees as an AMA Member Benefit and for Membership Promotion," to the Board of Trustees. Resolution 607, introduced by New York Delegate, Dr. Gregory L. Pinto, asked:

> That our American Medical Association (AMA) investigate mechanisms by which Members may receive a discount or waiver on CPT-related fees, specifically the fees associated with using CPT codes within electronic medical billing systems.

BACKGROUND ON AMA MEMBERSHIP DUES AND BENEFITS

As the largest association of physicians and medical students in the United States, the AMA provides a wide range of benefits and services to its members. In turn, members pay annual dues in accordance with their career progression, from medical students to residents and fellows to physicians. For example, dues applicable to first year medical school students are less than those applicable to physicians. Membership dues applicable to physicians are graduated over their first five years in practice, such that physicians pay full regular practice dues (i.e. $420) only after four years of medical practice. The AMA seeks to support physicians in the most prudent and direct ways possible. The AMA typically offers its physician members discounts on AMA-developed products sold directly to those members, such as published books, journals and newsletters.

EXPLANATION OF CPT LICENSING AND ROYALTIES

The Current Procedural Terminology (CPT) code set user-base is diverse and varied, and the AMA does not distinguish different types of users from one another, e.g., a nurse and a medical claims specialist both use CPT. In fact, approximately two-thirds of CPT users are not eligible for AMA membership because they are not physicians or medical students. CPT is typically licensed by organizations for all users of CPT – irrespective of user type – and the AMA does not receive information identifying the individuals covered under an organization's license.

Additionally, the majority of CPT licensing is completed by third party distributors such as software vendors (e.g., vendors of electronic medical billing systems) that embed CPT in their products to enable critical healthcare functions. Hundreds of such organizations contract with the AMA to distribute CPT domestically and globally. Distributor agreements specify a method of calculating a royalty due to the AMA from the distributor, but do not dictate the amount of CPT royalties (if any) to be charged by the distributors to their client, i.e. the end users of CPT. The AMA also does not dictate how distributors contract with their end user customers and these

practices vary widely. Some distributors elect to absorb the cost of CPT royalties paid to the AMA, or embed the cost into the cost of their product(s), while others choose to directly pass the cost through to their customers. Some distributors license their software (and in turn CPT) based on aggregate user counts, do not track the identities of specific users, and as a result, are unaware of an individual physician's usage of their product or that physician's membership status with the AMA.

As for CPT licensees who contract directly with the AMA (rather than through a distributor), most are large or mid-sized health systems, hospitals or practices. As mentioned above, the AMA does not receive information identifying specific users covered under the CPT license and thus is not able to confirm which users are physicians and whether any such physician user is an AMA member. We note that small practices with 25 or fewer CPT users are currently eligible for CPT royalty discounts between 13 and 22% when an AMA physician member purchases the license directly from the AMA, as AMA physician membership can be confirmed in this limited situation. The discount is applied to the entire license, not just the pro rata portion related to the individual physician member.

DISCUSSION

The CPT code set is a mission-driven product, which means that its royalties, like those from *JAMA* and other AMA assets, are used to carry out the mission to promote the art and science of medicine and the betterment of public health, to the benefit of all physicians and patients.

Development of a new CPT licensing and distribution process to administer a membership-based discount is at best impractical, requiring a complete reinvention of the AMA's licensing and distribution model, renegotiation of hundreds of contracts, and the introduction of cumbersome business processes that AMA's distributors are unlikely to accept. It would also require high volume and high frequency exchange of sensitive data and a large data reconciliation process. This approach would be inefficient, burdensome and costly for the AMA, the AMA's distributors and the distributors' licensees. Even if these significant changes were undertaken, it is unclear that savings would be delivered to AMA members, as distributors (often commercial companies) have different interests than membership organizations.

CONCLUSION

The AMA enhances its ability to achieve its mission by managing its assets in a fiscally prudent manner. Expanding CPT discounts beyond direct licensees would present significant policy, operational and contractual challenges that would divert resources from other important endeavors and result in unnecessary cost to the AMA. It is also very likely that the benefits of these discounts would accrue to distributors or licensee organizations rather than to AMA member physicians.

RECOMMENDATION

Through the analysis that led to this report, an opportunity was identified to improve AMA member benefits for direct licensees with 25 or fewer users by increasing their discount to 30%. This change will go into effect for the 2020 CPT data file. The increased discount will enable the AMA to continue to support its mission, while having a positive impact on AMA members in small practices. This is also consistent with other AMA Membership discount programs. Consequently, the Board of Trustees recommends that Resolution 607-A-18 not be adopted and that the remainder of this report be filed.

Fiscal note: None

REPORT 27 OF THE BOARD OF TRUSTEES (A-19)
Advancing Gender Equity in Medicine
(Reference Committee F)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-65.989 (1), "Advancing Gender Equity in Medicine," directs our AMA to "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." This report responds to this directive by: 1) describing issues associated with gender bias; 2) summarizing AMA positions and recommendations to promote gender equity in medicine; and 3) providing instructive principles for state and specialty societies, academic medical centers and other entities that employ physicians.

Gender-based disparities in compensation and advancement are pervasive in all medical practice settings, specialties, and positions. Research findings have noted that significant differences in salary exist after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue.

The AMA recognizes that gender inequity in medicine is a complex issue that requires a multilayered approach. Promoting gender equity in medicine requires an acknowledgement of the underlying causes of gender based disparities, creation of policies and resources that will promote gender equity, and collaboration to improve the environment for women and the profession overall.

This report offers principles intended to provide guidance on various issues associated with gender inequities in medicine. This report further recommends the development of policies and processes by various organizations to address harassment and discrimination.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-19

Subject: Advancing Gender Equity in Medicine

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

INTRODUCTION

American Medical Association (AMA) Policy D-65.989 (1), "Advancing Gender Equity in Medicine," directs our AMA to "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." This report responds to this directive.

AMA Policy D-65.989 was created following the adoption of Substitute Resolution 10-A-18, which was adopted in lieu of Resolution 10-A-18, "Advancing Gender Equity in Medicine;" Resolution 11-A-18, "Women Physician Workforce and Gender Gap in Earnings – Measures to Improve Equality;" Resolution 20-A-18, "Advancing the Goal of Equal Pay for Women in Medicine;" and Resolution 21-A-18, "Taking Steps to Advance Gender Equity in Medicine." Testimony in support of these items before the reference committee acknowledged the problem of gender disparities in medicine and noted a need for study. Testimony also reflected the need for our AMA to set an example on this issue, by committing to pay equity for its employees.

This report: 1) describes issues associated with gender bias; 2) summarizes AMA positions and recommendations to promote gender equity in medicine; and 3) provides clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians.

BACKGROUND

Gender disparities in advancement and income are pervasive in medical practice settings, specialties, and positions. Significant differences in salary exist after accounting for age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue. Advancement for women physicians has been slower than would be anticipated despite the growing number of women in medicine.

According to the U.S. Bureau of Labor Statistics, women earned about 82 percent of what men earned among full-time workers in all industries.[1] The gender pay disparity is indicative of "how far our nation still has to go to ensure that women can participate fully and equally in our economy," according to a report from the National Partnership for Women and Families.[2]

Gender-based disparities in income and advancement are also prevalent in medicine. The 2018 Medscape Physician Compensation Report noted considerable gaps in pay, with female physicians

in primary care earning nearly 18 percent less ($36,000) than their male counterparts. Among physicians the pay disparity was more pronounced with females earning 36.1 percent less ($95,000) than their male counterparts. This income disparity was consistent across all medical specialties.[3]

Ly, Seabury, and Jena conducted an analysis on income disparities among physicians, stratified by race and gender. Study results identified a considerable pay gap among black and white male physicians. The study also found that the income of black and white female physicians is "similar, but significantly lower than the incomes of male physicians."[4]

In the United States, women represent more than one third (35.2%) of the active physician workforce,[5] nearly half (45.6%) of all physicians-in-training[6] and more than half (50.7%)[7] of all entering medical students in MD-granting medical schools. Although the number of women entering the medical field has steadily increased, their proportion of leadership positions continues to be small. In a 2015 survey, women physicians (n = 3,285) identified the leadership positions they held as: medical director (35%), practice owner (23%), practice partner (13%), CEO (3%), and CMO (3%).[8]

Gender Disparities in Academic Medicine

A study of 10,241 physicians in 24 U.S. public medical schools found the annual salaries of female physicians were lower than those of male physicians, even after adjusting for "age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue." This study noted that "sex differences in salary were present at all faculty ranks and were largest among full professors." The average salary difference among male and female full professors was $33,620. Further, the adjusted salaries of female full professors (averaging $250,971) were comparable to those of male associate professors (averaging $247,212).[9]

Another study compared faculty income at 24 medical schools over a 17-year period and found that female physicians in academic medicine earned on average $20,000 less per year than their male counterparts. That is to say, female physicians earned 90 cents for every dollar made by male physicians.[10] These findings adjusted for factors such as specialty, experience, and faculty rank.

In addition to salary disparities, leadership disparities exist as well, with female physicians underrepresented in the higher ranks of medical school faculty. Although women accounted for 41.3 percent of full-time medical school faculty in 2018, they made up only 25 percent of tenured faculty (of all ranks) and only 24.6 percent of full professors and 37.5 percent of associate professors.[11, 12] Female physicians were also underrepresented in leadership positions at medical schools. Eighteen percent of department chairs (permanent and interim)[13] and eighteen percent of deans (permanent and interim) were women.[14]

DISCUSSION

Despite the increasing number of women physicians, gender-based differences in compensation and advancement exist in the medical profession. Researchers have cited factors such as specialty, experience, productivity, and work status as the reasons for these disparities. However, study results indicate that gender disparities persist even when controlling for age, specialty and practice characteristics. The following issues, which are often associated with gender inequities in medicine, have been highlighted for discussion.

Gender Bias and Discrimination

Women in medicine frequently encounter implicit and overt forms of gender bias as well as discrimination throughout their training and careers. Gender bias and discrimination can have a harmful effect on the professional experiences of women and impact opportunities for advancement such as promotions, grant awards, and manuscript acceptance. The formation of productive relationships with colleagues and mentors is often hindered by gender bias and discrimination. Study findings and anecdotal accounts have cited that women physicians are more likely to be disrespected by colleagues, held to a higher standard than male peers, introduced by their first names instead of professional titles, and excluded from events such as grand rounds.[15]

Adesoye, Mangurian, Choo, et al. conducted a study of physician mothers to assess their experiences with work place discrimination. More than three quarters (77.9%) of the respondents stated that they experienced some form of discrimination. Of those respondents, 66.3 percent reported gender discrimination and 35.8 percent reported maternal discrimination, which is defined as self-reported discrimination based on pregnancy, maternity leave or breastfeeding. Almost ninety percent (89.6%) of respondents who reported maternal discrimination noted that it was based on pregnancy or maternity leave. Nearly 48.4 percent of these respondents believed the discrimination was tied to breastfeeding. Those reporting maternal discrimination cited they experienced disrespectful treatment by nursing or other support staff, exclusion from administrative decision making, and gender disparities in salary and benefits.[16]

Implicit bias, explicit bias, stereotype threat and unconscious self-bias have implications for women as they may influence decisions on hiring, promotion, and compensation. Women may experience higher social costs for engaging in job negotiations and are less likely to negotiate.[17] Further, statistical discrimination is often associated with the stereotype that "women are less productive during childbearing years" and contributes to beliefs that women are less likely to aspire to leadership positions or assume roles with higher pay (e.g., undesirable call shifts).[18]

Mentorship and Sponsorship Opportunities

Women in medicine continue to be underrepresented in leadership positions. It has been noted that guidance and support from mentors and sponsors can positively impact career advancement. Mentorship and sponsorship can also mitigate the professional isolation that can undermine one's sense of confidence and belonging. However, there is a key distinction between mentorship and sponsorship. Mentors can work at any level in the organization and are selected based on expertise. Sponsors have a position of power that enables them to have significant influence on advancement decisions.

According to Ibarra et al., women tend to be "over-mentored but under-sponsored."[19] Although sponsorship has been positively associated with career advancement, women are typically sponsored less frequently than men. Hewlett et al. found that 13 percent of women had sponsors compared to 19 percent of men.[20] Similar to mentorship, there was a difference in outcomes for women and men. For example, an analysis of the National Institutes of Health (NIH) grant recipients found that sponsorship was correlated with success. Seventy-two percent of men and 59 percent of women who reported sponsorship were successful in obtaining an NIH grant compared to 57.7 percent of men and 44.8 percent of women who did not report sponsorship.[21]

Research findings have shown that mentorship and sponsorship outcomes vary for women and men, with women lagging on career advancement metrics. This may, in part, be attributed to men and women having different experiences with mentors. A study of graduates from top business

schools found that men were more likely to be mentored by someone from senior executive level positions (62% of men compared to 52% of women). After a two-year follow-up, it was found that men earned $9,260 more than women annually and were promoted 15 percent more often.[22]

Work-Life Balance

Many female physicians report work-life balance as a significant concern that may influence their career choices. This may be reflected in the disproportionate number of women physicians who choose part-time or reduced work hours to balance professional and personal life. In a recent survey, 92 percent of young physicians noted that they believe it is important to have a balance between work and personal responsibilities. However, only 65 percent felt they have achieved work-life balance.[23]

While male physicians are increasingly expressing interest in flexible family leave and work options, female physicians continue to bear primary responsibility for caregiving and may face more challenges in aligning their career goals with family needs. Nearly a quarter (22%) of female physicians reported working part-time compared to twelve percent of male physicians.[24] Further, a 2017 study found that hours worked by women physicians with children remained statistically lower when compared to women physicians without children.[25]

When professionals reach their mid-40s, many of them assume responsibility for eldercare, or providing care for older relatives. According to a 2017 Bureau of Labor Statistics report, more than twenty percent (21.4%) of adults between the ages of 45-54 and nearly a quarter (24.3%) of adults between the ages of 55-64 provide care for an older relative. This same report notes that there are currently 41.3 million adults that provide unpaid eldercare and the majority are women (56%).[26] Although flexible work options (e.g., part-time work, re-entry, etc.) are intended to balance professional and personal responsibilities, there is also an impact on income and earning potential. Additional accommodations, such as flexible scheduling time and re-entry assistance programs, need to be offered beyond parental and family leave.

Increased Risk of Burnout

Burnout among physicians has been associated with adverse quality outcomes, diminished patient satisfaction, increased job dissatisfaction, and reduction of work effort. More than half of U.S. physicians are experiencing symptoms of burnout and the prevalence of burnout in physicians is nearly two times greater than other professions. Similarly, the prevalence of burnout and depression among medical students and residents is higher than individuals of similar age.[27]

Findings from a survey of more than 15,000 physicians from 29 specialties noted that 50 percent of female physicians reported burnout, compared with 39 percent of their male peers.[28] Many factors contribute to burnout, including administrative burdens, challenges in working with electronic health records, discrimination, lack of respect, and maintaining work-life balance.

In addition, the conflict between professional and personal responsibilities has been associated with increasing burnout odds by 200 to 250 percent.[29] Women are often disproportionately responsible for childcare and family responsibilities. Further, maternal discrimination was associated with higher self-reported burnout (45.9% burnout in those with maternal discrimination compared to 33.9% burnout in those without).[30] Ultimately, it has been noted that “less pay combined with physician burnout might lead to more female physicians leaving the profession.”[31]

CONCLUSION

The AMA recognizes that gender inequity in medicine is a complex issue that requires a detailed, multifaceted approach. Promoting gender equity in medicine requires an acknowledgement of the underlying causes of gender-based disparities, creation of policies and resources that will promote gender equity, and collaboration to improve the environment for women and the profession as a whole.

Factors such as specialty, experience, productivity, and work status have been attributed to gender-based disparities in compensation and professional advancement. However, researchers have found that these disparities persist even when studies control for age, specialty and practice characteristics. Remaining disparities are attributed to a degree of gender discrimination and gender bias that can have a deleterious effect on the professional experiences of women and impact opportunities for advancement.

The proposed AMA Principles for Advancing Gender Equity in Medicine were derived from a review of current AMA policies on gender disparities, women in medicine, and equal opportunity. These policies were consolidated to ensure that AMA policy on gender equity in medicine is consistent and accurate. The principles being proposed in recommendation 1 incorporate relevant portions of the three existing AMA policies that are recommended for rescission in recommendation 2. Appendix A provides a comparison of the proposed language and the original language that is being modified. Appendix B lists the full text of the polices recommended for rescission.

RECOMMENDATIONS

The AMA recognizes that gender inequity in medicine is a complex, pervasive issue that requires a multilayered approach. Accordingly, the Board recommends that the following be adopted and that the remainder of the report be filed.

1. That our American Medical Association adopt the following language as policy, “Principles for Advancing Gender Equity in Medicine”:

   Our AMA:

   1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

   2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

   3. endorses the principle of equal opportunity of employment and practice in the medical field;

   4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;

   5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;

6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas. (New HOD Policy)

2. That our AMA rescind the following policies, as they have been incorporated into the "Principles for Advancing Gender Equity in Medicine":

   a. D-200.981, "Gender Disparities in Physician Income and Advancement"
   b. H-525.992, "Women in Medicine"
   c. H-65.968, "Equal Opportunity" (Rescind HOD Policy)

3. That our AMA rescind AMA Policy D-65.989 (1), "Advancing Gender Equity in Medicine," as this report has fulfilled the request for information on positions and recommendations regarding gender equity in medicine, including the development of clarifying principles. (Rescind HOD Policy)

4. That our AMA encourage state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine. (Directive to Take Action)

5. That our AMA encourage academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (Directive to Take Action)

6. That our AMA, modify Policy D-65.989, "Advancing Gender Equity in Medicine," and continue to: (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. (Modify HOD Policy)

7. That our AMA amend AMA Policy G-600.035, "The Demographics of the House of Delegates," to read as follows:

   a. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

   b. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.

   c. Future reports on the demographic characteristics of the House of Delegates should, whenever possible, ~~will~~ identify and include information on successful initiatives and best practices to promote diversity within~~, particularly by age,~~ state and specialty society delegations. (Modify Current HOD Policy)

Fiscal Note: Less than $5,000

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APPENDIX A: PROPOSED AMA POLICY: "PRINCIPLES FOR ADVANCING GENDER EQUITY" (WORKSHEET VERSION)

Note: The left column shows the proposed language for adoption; the right column shows the original language that is being modified and its policy number, if any.

Proposed language for adoption	Original language
Our AMA: 1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender)	Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; H-65.968
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;	(2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; H-65.968
	~~(3) affirms the concept of equal rights for men and women;~~ H-65.968
3. endorses the principle of equal opportunity of employment and practice in the medical field;	(4) endorses the principle of equal opportunity of employment and practice in the medical field. H-65.968
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;	Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine. H-525.992
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement and encourages physicians to engage in such activities;	--
6. declares that compensation should be equitable and based on comparable work at each career stage, demonstrated competencies/expertise and not based on personal characteristics;	--
	~~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;~~ D-200.981
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;	(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; D-200.981

8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and	(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; D-200.981
	~~(4) will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession;~~ D-200.981
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.	and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit. D-200.981

APPENDIX B: AMA POLICIES AND DIRECTIVES PROPOSED FOR RESCISSION

Equal Opportunity H-65.968
Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender; (3) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Gender Disparities in Physician Income and Advancement D-200.981
Our AMA: (1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist; (2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations; (3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession; (4) will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession; and (5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

Women in Medicine H-525.992
Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine.

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.

APPENDIX C: STATUS OF DIRECTIVES ASSOCIATED WITH AMA POLICY ADVANCING GENDER EQUITY IN MEDICINE D-65.989

Policy Language	Status
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.	AMA PolicyFinder was updated to include Advancing Gender Equity in Medicine D-65.989.
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.	Programming will be developed for future AMA meetings.
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.	A report with recommendations will be provided to the AMA House of Delegates at the 2019 Interim Meeting. This report will be based on data from the 1) Demographic Characteristics of the House of Delegates and AMA Leadership (CLRPD Report 1-A-19) and 2) results from an AMA staff survey used to collect information on committee composition, plenary speaker invitations, recognition awards, and grant funding.

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.	An evaluation of gender/demographic equity for pay practices in AMA's internal workforce is underway.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Report A-19

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Marta J. Van Beek, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

This report by the Committee at the 2019 Annual Meeting presents one recommendation.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, ("the Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers). The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation in which was added to the Glossary of the AMA Constitution Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual or work performance including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board Compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee recommend that the HOD affirm a codification of the current compensation principle, which occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base its recommendations for Officer compensation on the principle of the value of the work performed, consistent with IRS guidance and best practices as recommended by the Committee's external independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation with that of all other Officers (excluding Presidents and Chair) because these positions perform comparable work.

Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves Group, to update his 2007 research by providing the Committee with comprehensive advice and counsel on Officer compensation. The updated compensation structure was presented and approved by the HOD at I-11 with an effective date of July 1, 2012.

The Committee's I-13 report recommended and the HOD approved the Committee's recommendation to provide a travel allowance for each President to be used for upgrades because of the significant volume of travel in representing our AMA.

At I-16, based on the result of a comprehensive compensation review conducted by Ms. Becky Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee recommended and the HOD approved modest increased to the Governance Honorarium and Per Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition so that Internal Representation, in excess of eleven days, receives a per diem.

At A-18, based on a compensation review focused on the Presidents' and Chairs' compensation, the Committee recommended and the House approved a modest increase to their Honoraria, the first increase in ten years.

METHODOLOGY

At I-18, this Committee recommended and the House approved an Annual Health Insurance Stipend (Stipend) for the President, President-Elect and the Immediate Past President when replacement health insurance is needed because he/she loses health insurance coverage at their practice, university or hospital (collectively referred to as "Employer") when they reduce their work schedule to fulfill their responsibilities as President, President-Elect or Immediate Past President.

The amount of the Stipend was based on 70% of the then current Gold Plan premium in the President(s) state of residence for each covered family member. The Stipend ended when a President, President-Elect or Immediate Past President became Medicare eligible during their term in office because the Stipend was based on the President's need for health insurance which was met via Medicare.

The Committee heard testimony at Reference Committee F in support of the Stipend, however there were questions about the Stipend ending for the President's covered family members when the President became Medicare eligible while in office. The Committee completed additional research and concluded that revisions to the definitions were warranted because the President(s) covered family members also needed replacement health insurance when the President(s) lost insurance from his/her Employer upon reducing their work schedule to fulfill AMA responsibilities.

The Committee also noted that for clarity, the definition of the Stipend replaces "age 65" with "Medicare eligibility."

FINDINGS

The Committee notes that the President-Elect, President and Immediate Past President responsibilities require a significant time commitment in supporting our AMA in governance and representation functions. Our A-18 report noted that this level of responsibility results in a time commitment well above that required by other not-for-profit boards. The level of commitment needed in supporting our AMA may necessitate a President reduce his/her work schedule with his/her Employer to a part-time status which may result in a President and his/her covered family members losing their eligibility for Employer's health insurance coverage.

This Committee considers health insurance a necessity. At I-18 the Committee recommended and the House approved a Stipend for the President and his/her family when they lose their Employer's health insurance. This Committee recommends amending the definition of eligibility so that President(s) who already have health insurance coverage through Medicare when elected will not be eligible for the Stipend for themselves or family members. Additionally, this Committee recommends amending the eligibility definition so that if a President becomes Medicare eligible while in office, the President will be expected to enroll in Medicare and the Stipend will continue to cover family members who are not Medicare eligible. The amount of the Stipend will be adjusted accordingly. The Stipend would be reported as taxable income to the President(s).

RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report filed:

1. That Policy D-605.990 be appended by a new section XXIII as follows:

   Annual Health Insurance Stipend ("Stipend")
   The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate the President, President-Elect, and Immediate Past President when the President(s) lose(s) his/her Employer provided medical insurance coverage. President(s) who lose his/her Employer insurance will substantiate his/her eligibility for the Stipend by written notice to the Board Chair detailing the effective date of the loss of coverage and listing covered family members. The President receiving the Stipend will have the sole discretion to determine the appropriate health insurance for himself/herself and the family members; however, the Stipend will be calculated based on 70% of the then current Gold Plan premium for his/her state/county of residence.

   Should a President become Medicare eligible during his/her term(s), the Stipend will end for the President the month Medicare coverage begins. If the President has covered family members who are not Medicare eligible, the amount of the Stipend will be adjusted to cover only those family members until they become Medicare eligible. As family members become Medicare eligible, the President is expected to provide written notice of the event to the Board Chair and the Stipend will be adjusted accordingly the month Medicare coverage begins.

   In any case, the Stipend will end the sooner the President(s) obtains other health insurance coverage or the month following the end of his/her term as Immediate Past President.

   Should a President have health insurance coverage through Medicare when elected, he/she will not be eligible for the Stipend for themselves or family members.

The amount of the Stipend will be 70% of the then current Gold Plan premium in the President(s) state/county of residence for each covered family member. If there are multiple Gold Plans in the state/county, the Stipend will be based on the average of the then current Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year based on then Gold Plan premiums and covered family members.

The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable income for the President each calendar year and will be included in this Committee's annual report to the House which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services, and in-kind payments.

2. Except as noted above, there will be no other changes to the Officers compensation for the period beginning July 1, 2019. (Directive to Take Action)

Fiscal Note: The maximum annual stipend is estimated at $87,000. This is based on 70% of the highest 2018 Gold Plan Premium based on current Board demographics and assumes all 3 Presidents and spouses/partners would receive the stipend in the same year.

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	$290,160
Immediate Past President	$284,960
President-Elect	$284,960
Chair	$280,280
Chair-Elect	$207,480

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,300 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or $650.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-19)

Introduced by: Indiana

Subject: AMA Policy Statement with Editorials

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Freedom of speech is essential and all sides of an issue deserve to be discussed; and

Whereas, Our AMA has good policy on most medical issues; and

Whereas, The Aug. 22-29, 2017, *JAMA* published an editorial on Maintenance of Certification contrary to AMA policy; therefore be it

RESOLVED, That our American Medical Association include a policy statement after all editorials in which policy has been established to clarify our position. (Directive to Take Action)

Fiscal Note: Indeterminate.

Received: 03/06/19

RELEVANT AMA POLICY

AMA Publications G-630.090
AMA policy on its publications includes the following:
(1) JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.
(2) Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.
(3) Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.
(4) The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.
Res. 294, A-90 BOT Rep. G, A-91 BOT Rep. VV, I-92 BOT Rep. PP, A-93 Res. 622, I-96 Res. 612, A-97 Reaffirmed: Sunset Report and Appended: BOT Rep. 22, I-00 Consolidated: CLRPD Rep. 3, I-01 Appended: BOT Rep. 32, A-04 Modified: CCB/CLRPD Rep. 3, A-12 Modified: Speakers Rep., A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-19)

Introduced by: Susan R. Bailey, MD, Delegate; and Bruce A. Scott, MD, Delegate

Subject: Expectations for Behavior at House of Delegates Meetings

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Our American Medical Association House of Delegates (HOD) has adopted Policy H-140.837 declaring that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings and other AMA-sponsored meetings or events is prohibited conduct and is not tolerated; and

Whereas, Our AMA HOD has also adopted Policy D-140.954 calling for an external evaluation of the anti-harassment processes set forth in Policy H-140.837 with a report back at this meeting; and

Whereas, Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any other AMA-sponsored meeting or event; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits; and

Whereas, Harassing conduct includes, but is not limited to epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting; and

Whereas, Our Rules and Credentials Committee proposes and our AMA HOD adopts a rule at every meeting calling for respectful behavior at all times; and

Whereas, Our AMA HOD has collectively recognized the odious nature of harassing behaviors in its prior actions; and

Whereas, Every delegate and alternate delegate should acknowledge their role in preventing harassment at AMA meetings, but particularly at our own HOD meetings, as part of the meeting registration process; therefore be it

RESOLVED, That every AMA HOD delegate and alternate delegate shall, as a condition to receiving their credentials for any AMA HOD meeting, acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies (New HOD Policy); and be it further

RESOLVED, That any AMA HOD delegate or alternate delegate who knowingly fails to acknowledge and accept during the AMA HOD meeting registration process (i) AMA policies concerning conduct at AMA HOD meetings and (ii) applicable adjudication and disciplinary processes for violations of such policies shall not be credentialed as a delegate or alternate delegate at that meeting. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/09/19

RELEVANT AMA POLICY

Anti-Harassment Policy H-140.837

Our AMA adopts the following policy:

Anti-Harassment Policy Applicable to AMA Entities

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and

- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Anti-Harassment Policy

1. Reporting a complaint of harassment

Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy
H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.

Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.

2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18

Harassment Issues Within the AMA D-140.954

Our AMA will immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or attendees with report back regarding said processes and implementation at the 2019 Annual Meeting.

Citation: Emergency Res. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Creation of an AMA Election Reform Committee

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Members of our AMA House of Delegates cherish our democratic process; and

Whereas, Our current election and voting process for AMA officers and council positions consumes a lot of time and financial resources; and

Whereas, Election reform would allow for more time for policy and debate during HOD sessions; and

Whereas, Cost barriers are often an impediment to candidate elections; and

Whereas, There are significant technological advances that could allow for an expedited process of elections and debate; therefore be it

RESOLVED, That our American Medical Association appoint a House of Delegates Election Reform Committee to examine ways to expedite and streamline the current election and voting process for AMA officers and council positions (Directive to Take Action); and be it further

RESOLVED, That such HOD Election Reform Committee consider, at a minimum, the following options:

- The creation of an interactive election web page;
- Candidate video submissions submitted in advance for HOD members to view;
- Eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker and Board of Trustee positions;
- Move elections earlier to the Sunday or Monday of the meeting;
- Conduct voting from HOD seats (Directive to Take Action); and be it further

RESOLVED, That our AMA review the methods to reduce and control the cost of campaigns (Directive to Take Action); and be it further

RESOLVED, That the HOD Election Reform Committee report back to the HOD at the 2019 Interim Meeting with a list of recommendations. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is between $15K-$25K.

Received: 04/12/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-19)

Introduced by: Illinois

Subject: Engage and Collaborate with The Joint Commission

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The Joint Commission's stated mission is "to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value"; and

Whereas, The Joint Commission accredits a large number of hospitals in the United States; and

Whereas, Joint Commission standards established in 2000 prioritized pain management (including chronic non-cancer pain) guidelines over the root causes of pain [1]; and

Whereas, The manufacturer of OxyContin is believed to have provided funding for the Joint Commission's pain management educational programs during the time that these standards were developed; and

Whereas, As a result of these pain standards, the increased use of opioids may have been indirectly encouraged as a way to comply with the guidelines, even though there was little evidence or validation to support the long-term use of narcotics to treat chronic, non-cancer pain; and

Whereas, A very recent Cochrane Review [2] concluded that there is a "paucity of high-quality controlled evaluations of the effectiveness and the cost-effectiveness of external inspection systems"; and

Whereas, Another systematic review [3] came to a similar conclusion, stating that their "review did not find evidence to support accreditation and certification of hospitals being linked to measureable changes in quality of care"; therefore be it

RESOLVED, That our American Medical Association study and report back on any potential impact, influence, or conflicts of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians). (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

References:

1. Phillips DM. JCAHO Pain Management Standards are Unveiled. JAMA. 2000; 284(4):428-429.
2. Flodgren G, Goncalves-Bradley DC, Pomey MP. External inspection of compliance with standards for improved healthcare outcomes. Cochrane Database Syst Rev. 2016, Dec 2; 12. CD008992; doi:10.1002/14651858.CD008992.pub3.
3. Brubakk K, Vist GE, Bukholm G, et al. A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research. 2015; 15:280-290.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-19)

Introduced by: New York

Subject: State Societies and the AMA Litigation Center

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, According to their website, The Litigation Center is an integral part of the AMA's advocacy efforts for physicians and their patients, and can help state medical societies or other entities with legal issues of exceptional importance or which have national implications; and

Whereas, 'Medical societies can benefit from the actions of the Litigation Center in any number of ways, including participation as a party in a lawsuit, filing of an amicus curiae ("friend of the court") brief, financial grants, or in-kind services. Sometimes, the Litigation Center can help "level the playing field" when a physician feels overwhelmed by the legal system'; and

Whereas, The Litigation Center will on occasion approach a state medical society with an invitation to join in its efforts such as in preparing an amicus; and

Whereas, The AMA Board in consultation with the Litigation Center will interpret the will of or policy of the AMA House of Delegates in setting forth its legal strategy/approach; and

Whereas, There is sometimes a disjunction between the interpretation of AMA policy by the state medical society's leadership and the attorneys of the Litigation Center--because of the different perspective between attorneys and physicians; and

Whereas, This disjunction can prevent the state medical society from joining the AMA in an Amicus due to this disjunction (despite sharing a desire to achieve a similar outcome); and

Whereas, Typically the AMA recognizes that legal battle would be more effective were the pertinent state medical society to join an AMA amicus; therefore be it

RESOLVED, That when seeking a state medical society's support of an amicus brief on a legal matter, especially one pertaining to an issue in that state, the American Medical Association Litigation Center consider the state medical society's point of view in developing the argument, and maintain full disclosure during the drafting of the amicus or any change in strategy. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-19)

Introduced by: Resident and Fellow Section

Subject: Investigation into Residents, Fellows, and Physician Unions

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Approximately 13% residents and fellows are part of formal unions[1]; and

Whereas, The ACGME introduced the Clinical Learning Environment Review (CLER) program in 2012 where teaching hospitals are visited every 18 months[1]; and

Whereas, These visits are meant to “gain knowledge about how clinical sites are supporting the training of residents and fellows in the areas of patient safety, health care quality, supervision, transitions in care, duty hours, fatigue management, and professionalism” according to the journal of graduate medical education[1]; and

Whereas, The intention of the external program is to allow residents to “freely, accurately, and honestly describe their teaching hospital environment in order to identify areas of improvement”[1]; and

Whereas, In 2009 the ACGME recommended an internal institutional form or other mechanism to give residents the opportunity to raise questions about and discuss educational and working conditions[1]; and

Whereas, Resident unions can provide a unified voice encouraging inter-specialty communication and engagement in hospital wide safety and quality improvement; and

Whereas, The Committee of Interns & Residents (the largest housestaff union composed of nearly 14,000 interns, residents, and fellows in California, Florida, Massachusetts, New York, New Mexico, and Washington D.C.) was formed in 1957 and aims to be "the national voice for physicians-in-training, uniting and empowering them to create a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows, and their families"[2]; and

Whereas, There is still 87% of house staff not being represented by a union in this country; and

Whereas, Physicians as a whole could benefit from a union representing them and ensuring quality, safe, and evidenced based patient care; and

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[1] Flavio Casoy, MD and Joanne Suh, MD, “Patients lose when resident physicians are afraid to unionize,” *KevinMD.com*, January 5, 2014, https://www.kevinmd.com/blog/2014/01/patients-lose-resident-physicians-afraid-unionize.html.
[2] Committee of Interns and Residents, https://www.cirseiu.org.

Whereas, Insurance companies partnering with various entities (drug store chains/retail clinics, urgent care centers) and even corporations to provide care options to patients has not been proven to be evidenced based, safe, or cost effective[3]; and

Whereas, Physician membership, participation, and representation in organized medicine (including national organizations such as the American Medical Association and individual specialty societies) continues to be on the decline; and

Whereas, Physicians are increasingly becoming employed workers and 2016 was the year that marked the first time that physician practice owners are not the majority[4]; and

Whereas, Various mergers mean uncertainty for how physicians would be able to practice; and

Whereas, Patients are often being given an incorrect diagnosis and management; and

Whereas, This has caused physicians to become more divided by specialty and further marginalized due to the lack of unity and bargaining power; and

Whereas, Patient care choices are being dictated by insurance companies and coverage; and

Whereas, Physicians as a cohort benefit from the work done by physician medical societies even if they are not dues paying members leaving less resources for organized medical physician groups to operate on; and

Whereas, Many physicians cite the lack of time, lack of interest, and lack of agreement with organized physician medical groups as the reason for not joining organized medicine; and

Whereas, There are regional unions such as the Union of American Physicians and Dentists that have been established[5,6]; and

Whereas, A truly powerful physicians union will need to include all specialists[7]; and

Whereas, Other countries have successful models for a physician union[8]; and

Whereas, There is no national physician union representing physicians of all specialties in the U.S.; therefore be it

RESOLVED, That our American Medical Association study the feasibility of a national house-staff union to represent all interns, residents and fellows. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

[3] Reed Abelson and Julie Creswell, "The Disappearing Doctor: How Mega-Mergers Are Changing the Business of Medical Care," *The New York Times*, April 7, 2018, https://www.nytimes.com/2018/04/07/health/health-care-mergers-doctors.html.
[4] Brendan Murphy, "For first time, physician practice owners are not the majority," *AMA Wire*, May 31, 2017, https://wire.ama-assn.org/practice-management/first-time-physician-practice-owners-are-not-majority.
[5] Union of American Physicians and Dentists (UAPD), https://www.uapd.com/all-doctors-need-a-union/.
[6] Noam Scheiber, "Doctors Unionize to Resist the Medical Machine," *The New York Times*, January 9, 2016, https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html.
[7] Margalit Gur-Arie, "Physicians must unionize. Here's why.," *KevinMD.com*, January 12, 2015, https://www.kevinmd.com/blog/2015/01/physicians-must-unionize-heres.html.
[8] Yngre Laeger, https://www.laeger.dk/information-in-english-yngre-laege.

RELEVANT AMA POLICY

Resident Physicians, Unions and Organized Labor H-383.998
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.
Citation: CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Re-Establishment of National Guideline Clearinghouse

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas,The National Guideline Clearinghouse (NGC) was created in 1998 through a partnership between our AMA and American's Health Insurance Plans (formerly known as the American Association of Health Plans); and

Whereas, Our AMA supports the wide dissemination of high-quality clinical guidelines after appropriate input by relevant physician organizations and interested physicians (Policy H-410.980; and

Whereas, Our AMA supported the creation and establishment of the NGC (Policy H-410.965); and

Whereas, The NGC acted as a database of clinical practice guidelines, allowing side-by-side comparison of two or more guidelines with information regarding development, implementation and use; and

Whereas, Funding for the NGC abruptly ended on July 16, 2018, resulting in the immediate closure of the NGC as well as its website without plans for replacement; and

Whereas, As the volume of clinical knowledge expands exponentially, clinical guidelines can help accelerate the adoption of new medical knowledge in clinical practice but can also thwart adoption of new medical knowledge when 100% compliance is required or when poorly constructed; and

Whereas, Before its closure, the NGC maintained 1400 clinical guidelines meeting strict methological standards and received more than 200,000 visitors per month; therefore be it

RESOLVED, That our American Medical Association reaffirm Policy H-410.965, "Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities" (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

RELEVANT AMA POLICY

Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level H-410.980
Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..
(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.
(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.
(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.
(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.
(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.
(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.
(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.
(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.
(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.
Citation: (CMS Rep. D, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities H-410.965
(1) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse and ensure the integrity of the Clearinghouse clinical practice guideline database.
(2) Our AMA provides the relevant national medical specialty societies the opportunity to review and have input into proposed performance indicators before implementing any pilot-testing of such indicators.
(3) Our AMA continues to work with national medical specialty societies and others in the development of standards for the appropriate collection, analysis, and reporting of valid and reliable physician-specific clinical performance and outcomes data.
(4) Our AMA continues to work with the Agency for Health Care Policy and Research and the American Association of Health Plans to advance the establishment of the National Guideline Clearinghouse.
Citation: (BOT Rep. 8, I-97; Appended: BOT Rep. 13, A-98; Reaffirmed: Res. 702, I-98; Modified: BOT Rep. 12, A-00; Modified: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-19)

Introduced by: Resident and Fellow Section

Subject: Financial Protections for Doctors in Training

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and

Whereas, With Resident and Fellowship Matching, physicians do not have choice in the benefit package causing differences in retirement outcomes; and

Whereas, Physicians should be saving 15% of their funding towards retirements, but studies have shown that physicians have not been saving enough due to multiple reason including significant student debt, delayed start in professional life, and decreased financial literacy[1,2,3]; and

Whereas, Evidence has shown that employers who match retirement savings, result in employees saving significantly more annual for retirement4; therefore be it

RESOLVED, That our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training (New HOD Policy); and be it further

RESOLVED, That our AMA support that all programs provide financial advising to resident and fellows. (New HOD Policy)

Fiscal Note: Indeterminate.

Received: 05/01/19

References:
1. https://communications.fidelity.com/pdf/physicians-financial-checkup.pdf
2. https://www.amainsure.com/research-reports/2017-financial-preparedness-resident-physicians/index.html?page=1&utm_source=AMA%20Wire
3. https://www.mededpublish.org/manuscripts/847/v1
4. http://www.plansponsor.com/Employer_Contributions_Important_to_Employee_Retirement_Savings.aspx

RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
Residents and fellows have a right to:
A. An education that fosters professional development, takes priority over service, and leads to independent practice.
With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.
B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.
C. Regular and timely feedback and evaluation based on valid assessments of resident performance.
With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.
D. A safe and supportive workplace with appropriate facilities.
With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.
E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the

conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.
F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.
With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, “Resident/Fellow Clinical and Educational Work Hours,” for more information.
G. Due process in cases of allegations of misconduct or poor performance.
With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.
H. Access to and protection by institutional and accreditation authorities when reporting violations.
With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(A-19)

Introduced by: Women Physicians Section

Subject: Update to AMA Policy H-525.998, "Women in Organized Medicine"

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, AMA Policy H-140.837, "Anti-Harassment Policy", states that the AMA is "committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events;" and

Whereas, The AMA Code of Medical Ethics 9.1.3, "Sexual Harassment in the Practice of Medicine," states that "physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve;" and

Whereas, AMA Policy D-140.954, "Harassment Issues Within the AMA," states that the AMA "will immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or attendees with report back regarding said processes and implementation at the 2019 Annual Meeting;" and

Whereas, AMA Policy H-525.998, "Women in Organized Medicine," was adopted in 1981; and

Whereas, The fifth clause of AMA Policy H-525.998, "Women in Organized Medicine," states the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures should be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site; and

Whereas, The fifth clause of AMA Policy H-525.998 has been implemented[1] and since been superseded by current AMA policy; therefore be it

RESOLVED, That our AMA amend AMA Policy H-525.998, "Women in Organized Medicine," by deletion to read as follows:

Our AMA:
(1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;
(2) supports the concept of increased tax benefits for working parents;
(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and
(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs.~~; and~~
~~(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.~~ (Modify HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/01/19

Reference
1. Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures. *JAMA.* 1992;268(2):273.

RELEVANT AMA POLICY

Women in Organized Medicine H-525.998
Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;
(2) supports the concept of increased tax benefits for working parents;
(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings;
(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and
(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.
Citation: (BOT Rep. T, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03; Reaffirmed: CCB/CLRPD Rep. 4, A-13

E-9.1.3 Sexual Harassment in the Practice of Medicine
Sexual harassment can be defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.
Sexual harassment in the practice of medicine is unethical. Sexual harassment exploits inequalities in status and power, abuses the rights and trust of those who are subjected to such conduct; interferes with an individual's work performance, and may influence or be perceived as influencing professional advancement in a manner unrelated to clinical or academic performance harm professional working

relationships, and create an intimidating or hostile work environment; and is likely to jeopardize patient care. Sexual relationships between medical supervisors and trainees are not acceptable, even if consensual. The supervisory role should be eliminated if the parties wish to pursue their relationship. Physicians should promote and adhere to strict sexual harassment policies in medical workplaces. Physicians who participate in grievance committees should be broadly representative with respect to gender identity or sexual orientation, profession, and employment status, have the power to enforce harassment policies, and be accessible to the persons they are meant to serve.
AMA Principles of Medical Ethics: II,IV,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Anti-Harassment Policy H-140.837
Our AMA adopts the following policy:
Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.
Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.
Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.
Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Anti-Harassment Policy
1. Reporting a complaint of harassment
Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.

Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy
H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.
Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.
2. Investigations
Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.
3. Disciplinary Action
If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.
If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.
If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.
If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.
4. Confidentiality
To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.
[Editor's note. Individuals wishing to register a complaint with AMA's external vendor (Lighthouse Services, Inc.) may do so by calling 800-398-1496 or completing the online form at https://www.lighthouse-services.com/ama.]
Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18

Harassment Issues Within the AMA D-140.954
Our AMA will immediately engage outside consultants to evaluate current processes and, as needed, implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or attendees with report back regarding said processes and implementation at the 2019 Annual Meeting.
Citation: Emergency Res. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(A-19)

Introduced by: Illinois

Subject: Mitigating Gender Bias in Medical Research

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, A study published in the *Canadian Medical Association Journal* has shown that grant applications going through the peer review process submitted by women are scored lower than those submitted by men; and

Whereas, A study has shown that university professors in the basic sciences identified male applicants as superior to female applicants and deserving of higher compensation even though the application materials submitted were identical except for the names identifying them as male or female; and

Whereas, A study looking at the relationship between gender and the length and tone of letters of reference showed that female applicants were only half as likely as male applicants to receive an "excellent" letter versus a "good" letter, and that letters of reference for women applicants included substantially different adjectives, such as "diligent" and "hardworking," as opposed to "brilliant" and "trailblazer" used to describe male applicants; and

Whereas, Our AMA has comprehensive policy on gender equity within the organization and has committed to presenting a report at the 2019 Annual Meeting; and

Whereas, Our AMA has some policy relating to gender equity in regards to physician compensation and advancement, but nothing specifically relating to gender equity in academic or commercial medical research; therefore be it

RESOLVED, That our American Medical Association advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(A-19)

Introduced by:	Radiological Society of North America, American Society for Radiation Oncology, American Institute of Ultrasound in Medicine, Iowa
Subject:	Election Reform
Referred to:	Reference Committee F (Greg Tarasidis, MD, Chair)

Whereas, There is an arms race in terms of the number of emails, social media posts, handwritten notes and mailers which consumes thousands of hours of time when candidates and their team could be participating in online testimony and preparing for the AMA meeting; and

Whereas, Our candidates attend up to 30 interviews across the Federation consuming at least 5 hours of interview time alone not including traveling time; and

Whereas, Most have an “entourage” of 2 to 15 people which means that at least 10-75 hours of time is taken from their participation in their delegation deliberations and debate; and

Whereas, For the elections in 2018 with 24 people running in competitive elections this amounted to about 1800 hours of lost time at the meeting; and

Whereas, This time is a gross underestimation of the time involved given the walking between sessions; and

Whereas, This does not take into account the time taken from each delegation to participate in the interview process and the time spent waiting for candidates; and

Whereas, Candidates and campaign teams remain distracted by their campaigns throughout the reference committees and even during the business of the House of Delegates; and

Whereas, Even after the primary election, runoffs can consume a tremendous amount of time since they are done with paper; and

Whereas, Sponsoring societies spend extensive resources in the form of time and money to support their individual candidates; and

Whereas, Many qualified candidates from the House of Delegates have chosen not to run campaigns because the burden in terms of money and manpower are prohibitive; and

Whereas, The election process has not been updated in several years despite both our House otherwise going paperless and additional security and technology advancements during that time; and

Whereas, Many specialty societies already hold web-based or device-based elections with no perceived violation of security or confidence in the outcome; therefore be it

RESOLVED, That our American Medical Association create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making (Directive to Take Action); and be it further

RESOLVED, That our AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas:

a) Elections being held on the Sunday morning of the annual and interim meetings of the House of Delegates.
b) Coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously.
c) Separating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices)
d) An easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail.
e) Electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in order to facilitate timely results and minimal interruptions to the business.
f) Seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.
g) Address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.) (Directive to Take Action); and be it further

RESOLVED, That the task force report back to the HOD at the 2019 Interim meeting. (Directive to Take Action)

Fiscal Note: Estimated cost of $15K-$25K to implement resolution.

Received: 05/02/19

RELEVANT AMA POLICY

Elections. B-3.4
3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.
3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.
3.4.2.1 At-Large Trustees.
3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each

vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of Trustees to be elected.
3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.
3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.
3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.
3.4.2.3 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.
3.4.2.4 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.
3.4.2.5 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

Rules for AMA Elections G-610.020
(1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker, is responsible for declaring a violation of the rules;
(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. The Speakers may use additional means to make delegates aware of those members intending to seek election;
(3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the nominees for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates;
(4) An Election Manual containing information on all candidates for election shall continue to be

developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates;

(5) A reduction in the volume of telephone calls from candidates, and literature and letters by or on behalf of candidates is encouraged. The use of electronic messages to contact electors should be minimized, and if used must allow recipients to opt out of receiving future messages;

(6) At the Interim Meeting, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited at the Interim Meeting. It is permissible at the Interim Meeting for candidates seeking election to engage in individual outreach, such as small group meetings, including informal dinners, meant to familiarize others with a candidate's opinions and positions on issues;

(7) Our AMA believes that: (a) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides; (b) elected specialty society members should be identified in that capacity while serving their term of office; and (c) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose;

(8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, or (c) distributing stickers, buttons, etc. with the candidate's name on them. At these events, alcohol may be served only on a cash or no-host bar basis;

(9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at campaign parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates;

(10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other campaign memorabilia shall be distributed at any time;

(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker);

(12) At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place his or her name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker;

(13) Candidates for AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society;

(14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and

(15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA

website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.
Citation: CLRPD Rep. E, I-80; Res. 22, I-81; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CLRPD Rep. F, I-91; CCRC Special Report, I-92; CCRC Special Report I-93; Special Committee on Campaign and Elections and Reaffirmed Special Committee Report on Campaigns and Elections, I-96; Special Committee on Campaigns and Elections, A-97; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; CC&B Rep. 3, I-08; Modified: Rules and Credentials Rep. 1, A-11; Modified: Rules and Credentials Rep. 1, I-13; Appended: BOT Rep. 5, I-13; Modified: Res. 602, A-14; Modified: Speakers Rep. 1, I-14; Modified: Res. 1, A-15

Guiding Principles for House Elections G-610.021
The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:
(1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
(2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable.
(3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
(4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
(5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
(6) Service in any AMA leadership position should not assure ascendancy to another leadership position.
Citation: (CLRPD Rep. 4, I-01; Reaffirmed: CC&B Rep. 2, A-11)

Election Process G-610.030
AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
Citation: (Sub. Res. 3, I-74; Special Committee Report, A-86; Reaffirmed: CLRPD Rep. C, A-89; Amended: Sunset Report, I-96; Amended: Rep. of the Special Advisory Committee to the Speaker of the HOD, I-99; Reaffirmed: Sunset Report, A-00; BOT Report 23, A-01; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-19)

Introduced by: New Mexico

Subject: Request to AMA for Training in Health Policy and Health Law

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Healthcare in the United States is being largely managed and reshaped by hospital administrators, consultants and politicians, with relatively little substantive input from physicians; and

Whereas, Physicians who care for patients understand better than anyone the ways in which our healthcare system is broken and needs to be improved; and

Whereas, Dysfunction of our healthcare system and lack of opportunities for physicians to have a meaningful voice in bringing about needed changes, are significant contributing factors to physician dissatisfaction, frustration and burnout; and

Whereas, Physicians are disadvantaged by the lack of easily available education in health policy and health law, essential skills for navigating barriers and effecting change; and

Whereas, Existing fellowships in health policy and health law offered by outside organizations tend to promote the values and priorities of those organizations; therefore be it

RESOLVED, That our American Medical Association offer its members training in health policy and health law, and develop a fellowship in health policy and health law. (Directive to Take Action)

Fiscal Note: Estimated cost of $200,000 to implement resolution.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(A-19)

Introduced by: Minority Affairs Section

Subject: Language Proficiency Data of Physicians in the AMA Masterfile

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The U.S. population's linguistic demographics continue to diversify with over 350 languages spoken in the U.S.;[1] and

Whereas, Population estimates regarding individuals with limited English proficiency (LEP) suggest there are over 25 million people with LEP in the U.S., the majority (64%) of whom are Spanish speakers,[2-3] and with substantial additional population who may not have general LEP but may have difficulty communicating in English during medical encounters due to the complexity of health-related cultural-linguistic elements, illness-related stressors, and other concomitant access-to-care challenges in minority populations;[4-6] and

Whereas, The federal government mandates that health care be provided equitably to patients in their preferred language regardless of national origin or language preference;[7-8] and

Whereas, Data demonstrates that language concordance, defined as direct patient-physician communication in the same language, improves patient outcomes and satisfaction;[9-11] and

Whereas, Data demonstrates that language concordant care is superior to professional interpreter-mediated medical care;[12-13] and

Whereas, A majority of medical schools report offering opportunities for linguistic education for medical students in languages other than English (e.g. medical Spanish) due to patient population demographic needs and increasing student demand;[17] and

Whereas The long-term outcomes of medical school education in non-English medical communication skills, such as appropriate interpreter use,[18-19] cultural competency, and linguistic training (e.g., medical Spanish)[20] are currently unknown and would require collection and evaluation of physician language proficiency data; and

Whereas, Existing language concordance preliminary data of primary care providers' languages conducted in California demonstrates a gross language concordance mismatch compared to the regional population linguistic profile,[21] and conducting similar studies locally, regionally, and nationally would enable a needs assessment of available physician resources with regards to underserved populations; and

Whereas, the Six-point Physician Linguistic Proficiency Self-assessment Scale, from the *Adapted International Language Roundtable (ILR) Scale for Physicians*[23] can measure language fluency as follows:

- **Excellent –** Speaks proficiently, equivalent to that of an educated speaker, and is skilled at incorporating appropriate medical terminology and concepts into communication. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural references.
- **Very Good –** Able to use the language fluently and accurately on all levels related to work needs in a healthcare setting. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Language ability only rarely hinders him/her in performing at task requiring language; yet, the individual would seldom be perceived as a native.
- **Good –** Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics. Although cultural references, proverbs and the implications of nuances and idiom may not be fully understood, the individual can easily repair the conversation. May have some difficulty communicating necessary health concepts.
- **Fair –** Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar. The individual can get the gist of most everyday conversations but has difficulty communicating about healthcare concepts.
- **Poor –** Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry level questions. May require slow speech and repetition to understand. Unable to understand or communicate most healthcare concepts.
- **None –** Unable to function in the spoken language. Oral production is limited to occasional isolated words. Has essentially no communicative ability; therefore be it

RESOLVED, That our American Medical Association initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale for physicians to indicate their level of proficiency for each language besides English in the healthcare settings. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

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RELEVANT AMA POLICY

Support of Multilingual Assessment Tools for Medical Professionals H-160.914
Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages.
Citation: (Res. 703, A-12

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and
(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.
Citation: BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

Interpretive Services H-215.982
Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services.
Citation: (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: Res. 702, A-12

Medical School Language Electives in Medical School Curriculum H-295.870
Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives.
Citation: Res. 304, A-07; Reaffirmed: CME Rep. 01, A-17

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Citation: Res. 006, A-17

Interpreter Services and Payment Responsibilities H-385.917
Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
Citation: (CMS Rep. 5, A-11

Patient Interpreters H-385.928
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.
Citation: (Res. 219, I-01; Reaffirmed: BOT Rep 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-14
Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive,

ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.
Citation: BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03; Reaffirmation A-09; Reaffirmation: A-17

Interpreters For Physician Visits D-90.999
Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.
Citation: (BOT Rep. 15, I-98; Reaffirmation I-03; Modified: BOT Rep. 28, A-13; Reaffirmation A-14

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.
Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17

Certified Translation and Interpreter Services D-385.957
Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.
Citation: Res. 703, A-17

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;
(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;
(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;
(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and
(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.
Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17

E-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 patientsclinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.
This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.
To fulfill this professional obligation in their individual practices physicians should:
(a) Provide care that meets patient needs and respects patient preferences.
(b) Avoid stereotyping patients.
(c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
(e) Encourage shared decision making.

(f) Cultivate effective communication and trust by seeking to better understand factors that can influence patientshealth care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.
The medical profession has an ethical responsibility to:
(g) Help increase awareness of health care disparities.
(h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
(i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.
AMA Principles of Medical Ethics: I,IV,VII,VIII,IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(A-19)

Introduced by: Minority Affairs Section

Subject: Racial and Ethnic Identity Demographic Collection by the AMA

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, An estimated 108 million adults (33% of the adult population) in the United States are Black or African American, American Indian and Alaska Native, Native Hawaiian or Other Pacific Islander, or Hispanic or Latino;[1] and

Whereas, Only 9.2% of practicing physicians are historically underrepresented minority groups in medicine (URMs)[2]; and

Whereas, Physicians who are minorities are more likely to serve those communities and addressing the need for more minority physicians may help mitigate the continued disparities in health outcomes seen within unrepresented minority populations in the US;[3] and

Whereas, Medical organizations (e.g. Association of American Medical Colleges) collect racial and ethnic minority identity demographics[4]; and

Whereas, Pursuant to AMA Policy G-635.125, the AMA gathers stratified demographics of its AMA membership, the nature of which includes age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty; and

Whereas, The AMA does not consistently collect race/ethnicity data from its membership; and

Whereas, The AMA does not have existing policy to consistently collect racial and ethnic minority status in the AMA Physician Masterfile for medical students, residents, fellows, and practicing physicians; and

Whereas, Consistent collection of race/ethnicity data will empower the AMA to address workforce diversity and the professional needs of underrepresented minority medical students, residents, fellows, and practicing physicians; therefore be it

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[1] United States Census Bureau Population Estimates, Available for URL: https://www.census.gov/quickfacts/fact/table/US/PST045218. Accessed on April 14, 2019

[2] Deville C, Hwang WT, Burgos R, Chapman CH, Both S, Thomas CR Jr. Diversity in Graduate Medical Education in the United States by Race, Ethnicity, and Sex, 2012. JAMA Intern Med. 2015 Oct;175(10):1706-8. doi: 10.1001/jamainternmed.2015.4324.

[3] Johnson SR. Black and Hispanic doctors still underrepresented in the U.S https://www.modernhealthcare.com/article/20150824/NEWS/150829945/black-and-hispanic-doctors-still-underrepresented-in-the-us. Accessed on April 14, 2019

[4] American Association of Medical Colleges (AAMC) Total Enrollment by U.S. Medical School and Race/Ethnicity (Alone), 2018-2019. Available at https://www.aamc.org/download/321540/data/factstableb5-1.pdf Accessed on April 14, 2019

RESOLVED, That our American Medical Association develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to consistently include racial and ethnic minority demographic information for physicians and medical students. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

AMA Membership Demographics G-635.125
1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and BOT Rep. 26, A-10 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Appended: Res. 603, A-17

The Demographics of the House of Delegates G-600.035
1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. 3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty CCB/CLRPD Rep. 3, A-12 Appended: Res. 616, A-14 Appended: CLRPD Rep. 1, I-15 Modified: Speakers Rep., I-17

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16

Revisions to AMA Policy on the Physician Workforce H-200.955
It is AMA policy that:
(1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
(2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will

independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
(3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
(4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
(5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
(6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
(7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencys physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17

Increasing Demographically Diverse Representation in Liaison Committee on Medical Education Accredited Medical Schools D-295.322
Our AMA will continue to study medical school implementation of the Liaison Committee on Medical Education (LCME) Standard IS-16 and share the results with appropriate accreditation organizations and all state medical associations for action on demographic diversity.
Citation: (Res. 313, A-09; Modified: CME Rep. 6, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(A-19)

Introduced by: Medical Student Section

Subject: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, The World Health Organization (WHO) has declared climate change to be the greatest threat to global health in the 21st century, with expected consequences including the spread of disease, drought, and forced migration secondary to the increased incidence of destructive 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, including H-135.923 and H-135.938[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 previously recommended communicating with patients through text, email and telephone to increase access to care, save patients time and fuel cost, and help reduce the overall footprint of obtaining care[3]; and

Whereas, The AMA has also recommended that medical practices and facilities "[p]rint double-sided or go paperless with an electronic health record, and [u]se 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 editorially independent, but an associated and reflective publication of the principles of the AMA[5]; and

Whereas, *JAMA* currently automatically enrolls members of the Medical Student Section in a weekly hard-copy subscription in addition to sending an online copy via email; and

Whereas, Reducing the quantity of printed pages could result in substantial savings for *JAMA*, and the AMA at large, which could directed to pursue other AMA policy priorities and would be consistent with the AMA's public exhortations to "go green"[6]; and

Whereas, Reduction in paper waste by eliminating redundant hard copy subscriptions would reduce the AMA's carbon footprint, and comply with the *AMA Journal of Ethics* and American College of Physicians (ACP) recommendations 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 American Medical Association change existing automatic paper *JAMA* subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to receive paper *JAMA*, in order to support broader climate change efforts. (Directive to Take Action)

Fiscal Note: not yet determined.

Received: 05/09/19

References:

1. WHO calls for urgent action to protect health from climate change – Sign the call. World Health Organization. http://www.who.int/globalchange/global-campaign/cop21/en/. Published April 14, 2016. Accessed September 22, 2018.
2. AMA Adopts New Policies to Improve Health of Nation. Selecting & Using a Health Information Exchange | AMA. https://www.ama-assn.org/ama-adopts-new-policies-improve-health-nation. Published November 15, 2016. Accessed September 22, 2018.
3. Lower Costs by Going Green! https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf. Published 2017. Accessed September 22, 2018.
4. Lower Costs by Going Green! https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf. Published 2017. Accessed September 22, 2018.
5. Davies HTO, Rennie D. Independence, Governance, and Trust: Redefining the Relationship Between JAMA and the AMA. JAMA. 1999;281(24):2344–2346. doi:10-1001/pubs.JAMA-ISSN-0098-7484-281-24-jed90044
6. Lower Costs by Going Green! https://www.ama-assn.org/sites/default/files/media-browser/public/ps2/transition-green-physician-practice.pdf. Published 2017. Accessed September 22, 2018.
7. AMA Adopts New Policies to Improve Health of Nation. Selecting & Using a Health Information Exchange | AMA. https://www.ama-assn.org/ama-adopts-new-policies-improve-health-nation. Published November 15, 2016. Accessed September 22, 2018.

RELEVANT AMA POLICY

AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
Citation: Res. 924, I-16

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

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

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921
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.
Citation: BOT Rep. 34, A-18

Global Climate Change - The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population.
Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

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.
Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(A-19)

Introduced by: Minority Affairs Section

Subject: TIME'S UP Healthcare

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, TIME'S UP was established in response to the common experience of power inequity and unsafe workplaces for women and other underrepresented groups everywhere, women in healthcare took notice; and

Whereas, TIME'S UP launched one year ago, women from across industries have come together to address systemic inequality and injustice in the workplace; and

Whereas, The TIME'S UP Healthcare initiative (https://www.timesuphealthcare.org) launched on February 28, 2019; and

Whereas, TIME'S UP Healthcare is a non-profit initiative of the Time's Up Foundation, which insists on safe, fair and dignified work for women in all healthcare settings; and

Whereas, The mission of TIME'S UP Healthcare is to unite national efforts to bring equity, inclusion and safety to the healthcare industry; and

Whereas The TIME'S UP raises awareness and knowledge about inequity and harassment and their effect on healthcare; and

Whereas, TIME'S UP Healthcare is adding its voice to that effort and calling for systemic change in the workplace culture in healthcare; and

Whereas, Although women make up over 80% of the healthcare workforce, the decision makers, including hospital leadership, executives and association presidents, are largely men; and

Whereas, Physicians continue to work in environments highly tolerant of gender-based harassment; and

Whereas, Gender-based harassment undermines women's professional and educational attainment and mental and physical health; and

Whereas, Gender-based harassment has negative effects of psychological well-being; and

Whereas, At the 2018 Annual Meeting of the American Medical Association House of Delegates, powerful testimony was delivered about the experiences of members and staff who have experienced harassment at AMA meetings and facilities; and

Whereas, The Board of Trustees responded to the will of the House to enact policies that will decrease the likelihood of gender-based harassment experienced by AMA staff or members; and

Whereas, TIME'S UP "partners" are organizations and societies/associations that have the ability to work to develop policies and education to transmit to their members; and

Whereas, TIME'S UP partners (as of March 8, 2019) include American College of Physicians, American Nurses Association, American Medical Women's Association, Council of Medical Specialty Societies, National Medical Association, and Service Employees International Union (SEIU); and

Whereas, TIME'S UP partners pledge their commitment to and alignment with TIME'S UP Healthcare core statements confirming:

- that sexual harassment and gender inequity have no place in the healthcare workplace;
- that we are committed to preventing sexual harassment and gender inequity and protecting and aiding those who are targets of harassment and discrimination;
- that we believe every employee should have equitable opportunity, support, and compensation;
- that we cannot address a problem without understanding its scope and impact;
- that we will measure and track sexual harassment and gender-based inequities occurring in our institution; and

Whereas, The process is not associated with a fee and takes less than two minutes to complete the electronic form on the TIME's UP Healthcare website; and

Whereas, By becoming a TIME'S UP partner, our American Medical Association would publicly demonstrate our commitment to strengthen the structures, processes, and outcomes that will allow us to achieve safe, dignified, and equitable workplace and environment; therefore be it

RESOLVED, That our American Medical Association evaluate TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with report back at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/09/19

RELEVANT AMA POLICY

Anti-Harassment Policy H-140.837
Our AMA adopts the following policy:
Anti-Harassment Policy Applicable to AMA Entities
It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events.
Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Sexual Harassment
Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.
Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.
Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.
Anti-Harassment Policy
1. Reporting a complaint of harassment
Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.
Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy
H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.
Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.
2. Investigations

Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.

3. Disciplinary Action

If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.

If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.

If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.

If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.

4. Confidentiality

To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.

[Editor's note. Individuals wishing to register a complaint with AMA's external vendor (Lighthouse Services, Inc.) may do so by calling 800-398-1496 or completing the online form at https://www.lighthouse-services.com/ama.]

Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(A-19)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Disabled Physician Advocacy

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

Whereas, Physicians with disabilities can be stigmatized, marginalized in society as a whole and within the medical community; and

Whereas, Physicians with disabilities can provide valuable services not only to patients, but also to their practices and the community of medicine; and

Whereas, Physicians with disabilities have specific legal rights to accommodation and absence of discrimination of which they may not be aware; and

Whereas, Physicians with disabilities may experience profound social, cultural and economic disadvantage and exclusion; and

Whereas, Promoting progressive removal of barriers to the full and effective participation of persons with disabilities in all aspects of development, and promoting the equal enjoyment by persons with disabilities of civil, political, economic, social and cultural rights will further the equalization of opportunities and contribute to the realization of a “society for all” in the twenty-first century; and

Whereas, Disabled physicians would benefit from the identification of support groups, resources for retraining, opportunities to work with medical students, residents and physicians in practice as well as all other resources to facilitate their inclusion in the medical community; therefore be it

RESOLVED That our American Medical Association study and report back on eliminating stigmatization and enhancing inclusion of disabled physicians including but not limited to:

1) Enhancing representation of disabled physicians within the AMA.

2) Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA (Directive to Take Action); and be it further

RESOLVED That our AMA identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable disabled physicians to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

1. General website identifying issues and needs of physicians with disabilities https://www.physicianswithdisabilities.org/
2. https://journalofethics.ama-assn.org/article/why-increasing-numbers-physicians-disability-could-improve-care-patients-disability/2016-10
3. https://www.nytimes.com/2017/07/11/upshot/doctors-with-disabilities-why-theyre-important.html
4. AAMC report: Accessibility, Inclusion, and Action in Medical Education Lived Experiences of Learners and Physicians With Disabilities March 2018
5. The Physically Disabled Physician https://jamanetwork.com/journals/jama/article-abstract/366379
6. DeLisa JA, Thomas P: Physicians with disabilities and the physician workforce: A need to reassess our policies. Am J Phys Med Rehabil 2005;84:5–11.
7. Zazove P, Case B, Moreland C, et al. U.S. medical schools' compliance with the Americans with Disabilities Act: findings from a national study. Acad Med. 2016;91(7):979-986.
8. Gostin LO. The Americans with Disabilities Act at 25: the highest expression of American values. JAMA. 2015;313(22):2231-2235.ArticlePubMedGoogle ScholarCrossref
9. Meeks L, Jain NR. The Guide to Assisting Students With Disabilities: Equal Access in Health Science and Professional Education. New York, NY: Springer; 2015.
10. Cassel EJ. The nature of suffering and the goals of medicine. N Engl J Med. 1982;306(11):639-645.PubMedGoogle ScholarCrossref
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12. Searcy CA, Dowd KW, Hughes MG, Baldwin S, Pigg T. Association of MCAT scores obtained with standard vs extra administration time with medical school admission, medical student performance, and time to graduation. JAMA. 2015;313(22):2253-2262.ArticlePubMedGoogle ScholarCrossref
13. University of California San Francisco. The Coalition for Disability Access in Health Science and Medical Education. 2015. http://meded.ucsf.edu/msds/coalition. Accessed February 13, 2016.
14. Health Care Professionals with Disabilities Career Trends, BestPractices and Call-to-Action Policy Roundtable https://www.dol.gov/odep/alliances/nondalliance roundtablereport.pdf

Reference Committee G

BOT Report(s)

13 Employed Physician Bill of Rights and Basic Practice Professional Standards

15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization

31 Non-Payment and Audit Takebacks by CMS

32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff

CMS Report(s)

01 Council on Medical Service Sunset Review of 2009 AMA House Policies

07 Hospital Consolidation

08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor

09 Health Plan Payment of Patient Cost-Sharing

10 Alternative Payment Models and Vulnerable Populations

11 Corporate Investors

Resolution(s)

701 Coding for Prior Authorization Obstacles

702 Peer Support Groups for Second Victims

703 Preservation of the Patient-Physician Relationship

704 Prior Authorization Reform

705 Physician Requirements for Comprehensive Stroke Center Designation

706 Hospital Falls and "Never Events" - A Need for More in Depth Study

707 Cost of Unpaid Patient Deductibles on Physician Staff Time

708# Access to Psychiatric Treatment in Long Term Care

709# Promoting Accountability in Prior Authorization

710# Council for Affordable Quality Healthcare Attestation

711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs

712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives

Contained in the Handbook Addendum

REPORT 13 OF THE BOARD OF TRUSTEES (A-19)
Employed Physician Bill of Rights and Basic Practice Professional Standards
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, "Employed Physician Bill of Rights." Resolution 701-A-18 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician's Bill of Rights. The HOD also referred Resolution 702-A-18, "Basic Practice Professional Standards of Physician Employment," which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

The Board's analysis found that most of the concepts set forth in Resolutions 701 and 702-A-18 are already addressed in AMA policy, and the Board recommends reaffirmation of these policies. In some cases, the proposed policies are inconsistent with existing policy. Finally, the Board's analysis identified two themes in Resolutions 701 and 702-A-18 not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and recommends adoption of new policy in these areas.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-19

Subject:	Employed Physician Bill of Rights and Basic Practice Professional Standards (Resolution 701-A-18 and Resolution 702-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, Employed Physician Bill of Rights. Resolution 701 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician's Bill of Rights. The HOD also referred Resolution 702, Basic Practice Professional Standards of Physician Employment, which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts. These resolutions are reproduced in full in the appendix.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

BACKGROUND

AMA policy on physician employment matters dates back more than two decades and covers an extensive range of issues. In 2012, recognizing the growing number of physicians becoming employed, the AMA consolidated and expanded this guidance in the form of the AMA Principles for Physician Employment (Policy H-225.950), which have since been updated a handful of times. As noted in the original preamble, the Principles "are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment." In addition to this body of policy, the AMA has developed a variety of resources to help physicians navigate physician-employer relations, most notably its model employment agreements.

RESOLUTION 701-A-18, EMPLOYED PHYSICIAN BILL OF RIGHTS

The first resolve of Resolution 701-A-18 asks the AMA to adopt an "Employed Physician Bill of Rights," the provisions of which are delineated in resolves 2-11. We discuss below the asks of each resolve with respect to the AMA Principles for Physician Employment and other AMA policy.

Resolve 2 asks "That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational

endeavors and preparation, committee participation, student/resident activities and administrative responsibilities."

Resolve 2 is addressed by Policy H-225.997, "Physician-Hospital Relationships," which is also more nuanced than the proposed policy position:

> "(4) Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities for the purpose of improving patient care; providing continuing education for the benefit of the medical staff; and assisting in the training of physicians and allied health personnel. Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefore."

Resolve 3 asks "That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits."

While existing policy recognizes several areas in which employed physicians should have "freedom," it does not explicitly address academic freedom. We therefore propose an amendment to Policy H-225.950, "AMA Principles for Physician Employment," as follows:

> "(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. <u>Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.</u>"

Resolve 4 asks "That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems."

Current AMA policy does not explicitly address administrative burden on employed physicians. While physicians must ultimately take responsibility for the care of their patients, which includes documentation and other uses of the electronic medical record, they should not be burdened with such tasks to the detriment of patient care. We therefore recommend adoption of new AMA policy as follows:

> Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Resolve 5 asks "That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives."

Resolve 5 is addressed by Policy H-225.950, "AMA Principles for Physician Employment," and H-225.942, "Physician and Medical Staff Member Bill of Rights:"

H-225.905: "(5)(c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians—not lay administrators—should be ultimately responsible for all peer review of medical services provided by employed physicians."

H-225.942: "(IV)(d) "individual medical staff members have "the right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty."

Resolve 6 asks "That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization."

AMA Policy H-225.950, "AMA Principles for Physician Employment," recognizes two important points related to Resolve 6: First, that employed physicians do in fact owe a duty of loyalty to their employers, which may reasonably limit their rights to engage in activities that conflict with the financial or other interests of the employer–for example, moonlighting at a competing hospital:

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

At the same time, the policy states that "employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees."

We believe that these two statements taken together appropriately addresses the matter of "physician activities performed outside of defined employed-time boundaries" and recommend no amendments to existing policy. Physicians are encouraged to carefully negotiate their contract to ensure their desired level of independence outside the context of employed time is protected.

Resolve 7 asks "That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period."

Resolve 7 is addressed by two provisions of Policy H-225.955, "Protection of Medical Staff Members' Personal Proprietary Financial Information," to which we recommend a clarifying edit:

"(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate."

"(2) Medical staff members' personal financial information shall remain confidential except for disclosure to those with a bona fide need for access to such information. The security and storage of such information, including electronic and paper-based, should be at the same level as that afforded to other data and files in the hospital, such as patient and peer review

> information that enjoy confidentiality and privacy protections, including restricted access, password protection and other protective mechanisms."

Resolve 8 asks "That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians."

Resolve 8 is addressed by Ethical Opinion 11.2.3.1, "Restrictive Covenants," and Policy H-225.950, "AMA Principles for Physician Employment," both of which discourage physicians from entering into employment contracts that contain restrictive covenants, regardless of status as a partner or salaried employee:

> Code of Medical Ethics 11.2.3.1: "Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms. Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Physicians should not enter into covenants that: (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) Do not make reasonable accommodation for patients' choice of physician."
>
> H-225.950: "(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment."

Resolve 9 asks "That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines."

Resolve 9 is inconsistent with Policy H-300.982, "Maintaining Competence of Health Professionals," which places on the physician the burden of the cost of completing continuing medical education:

> "(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education."

We note also that compensation or reimbursement for CME is a fairly common benefit of employment which physicians should consider carefully as they negotiate employment contracts. Refer to the AMA annotated model physician employment agreements for guidance.[1]

Resolve 10 asks "That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act)."

Given that collective bargaining is largely toothless without the specter of a strike, resolve 10 is arguably inconsistent with Ethical Opinion 1.2.10, "Political Action by Physicians," and Policy H-383.998, "Resident Physicians, Unions and Organized Labor," which discourage physicians

[1] These and other resources on employment contracts are available at ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.

from withholding essential medical services from patients or otherwise disrupting patient care as a bargaining tactic:

> Code of Medical Ethics 1.2.10: "Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised; (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice; (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients; (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate."

> H-383.998: "Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients."

Resolve 11 asks "That this bill of rights include the principle that all physicians be empowered to first be the patient's advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient's health care and dignity."

Resolve 11 is addressed by Policy H-225.950, "AMA Principles for Physician Employment:"

> H-225.950: "(2)(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated."

> H-225.950: "(1)(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests."

Additionally, as noted in the AMA's history of its Code of Medical Ethics, the Code "is rooted in an understanding of the goals of medicine as a profession, which dates back to the 5th century BCE and the Greek physician Hippocrates, to relieve suffering and promote well-being in a relationship of fidelity with the patient."

RESOLUTION 702-A-18, BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT

Resolution 702-A-18 identifies a set of "best practices" related broadly to physician employment and asks our AMA to support specific contract provisions that might improve the physician experience in the employed settings:

That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximum employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic health record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

While none of these aims is objectionable on its face, the creation of such a list would seem to be inconsistent with an overarching theme of AMA employment-related policy: that physicians must be free to and should exercise self-determination in employment contracting. Specifically, Policy H-225.950, "AMA Principles for Physician Employment," avers that "Physicians should be free to enter into *mutually satisfactory* contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession" (emphasis added). Furthermore, "physicians should never be coerced into employment" and "employment agreements between physicians and their employers should be negotiated in good faith," with "both parties [being] urged to obtain the advice of legal counsel experienced in physician employment matters…."

Individual physicians must determine for themselves what they seek in employment arrangements and how they weigh these various desires. For example, some physicians may choose to forego work flexibility or smaller workload in exchange for greater compensation; others may choose to forego additional compensation to work for an organization that provides a higher level of administrative support. So long as they balance these desires in a manner that does not compromise the ethical principles of the medical profession, physicians should be free to negotiate their contracts as they see fit. Physicians are encouraged to use AMA resources in this regard, such as the AMA's model physician employment agreements. These valuable resources include a thorough description of basic contract terms typically found in an employment agreement, an in-depth explanation of the significance of such provisions and language that benefits the physician employee, and important examples of language that may be problematic to the physician employee.

Finally, we note that some sections of Resolution 702-A-18—in particular, items 1-3—raise an issue discussed earlier in this report: appropriate levels of support for employed physicians. While physicians should be free to negotiate for their desired level of staffing, AMA should ensure that physicians are provided at least the level of staffing needed to ensure that they can deliver safe,

high-quality care to their patients. We therefore recommend adoption of new AMA policy as follows (and as presented in the discussion on Resolve 4 of Resolution 701-A-18):

> Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

CONCLUSION

The concepts set forth in Resolution 701-A-18, "Employed Physician Bill of Rights," and Resolution 702-A-18, "Basic Professional Standards of Physician Employment," are for the most part addressed by a variety of existing AMA policies. We recommend reaffirmation of these policies. In a few instances, the concepts set forth in Resolutions 701 and 702-A-18 are inconsistent with current policy, in which case we recommend no change in policy. Finally, we have identified two themes not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and we recommend adoption of new policy in these areas.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 701-A-18 and Resolution 702-A-18, and the remainder of the report be filed:

1. That our AMA reaffirm the following policies:

   - H-225.950, AMA Principles for Physician Employment,
   - H-225.997, Physician-Hospital Relationships,
   - H-225.942, Physician and Medical Staff Member Bill of Rights,
   - H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information,
   - H-300.982, Maintaining Competence of Health Professionals, and
   - H-383.998, Resident Physicians, Unions and Organized Labor. (Reaffirm HOD Policy)

2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:

   > "(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used <u>only</u> so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate." (Modify Current HOD Policy)

3. That our AMA amend policy H-225.950, AMA Principles for Physician Employment:

   > "(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. <u>Employed physicians also should enjoy academic freedom to pursue clinical</u>

research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization." (Modify Current HOD Policy)

4. That our AMA advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients. (New HOD Policy)

Fiscal Note: Less than $500.

Appendix

Resolution 701-A-18, “Employed Physician’s Bill of Rights”

RESOLVED, That our American Medical Association adopt an “Employed Physician’s Bill of Rights”; and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities; and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits; and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems; and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives; and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization; and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period; and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians; and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines; and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity.

Resolution 702-A-18, “Basic Practice Professional Standards of Physician Employment”

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other “greater societal good” organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.

REPORT 15 OF THE BOARD OF TRUSTEES (A-19)
Physician Burnout and Wellness Challenges
Physician and Physician Assistant Safety Net
Identification and Reduction of Physician Demoralization
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting and presented in BOT Report 31-A-18. Based on testimony in Reference Committee G asking for further clarifications, BOT 31-A-18 was referred back for a report at the 2019 Annual Meeting.

The AMA is committed to addressing the issues of physician, resident, and medical student burnout, stress and suicide. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting.

This report discusses the numerous efforts underway at the AMA to help identify and provide solutions to the issue and presents recommendations to amend existing HOD Policy related to the issues discussed throughout the report.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-19

Subject:	Physician Burnout and Wellness Challenges (Resolution 601-I-17); Physician and Physician Assistant Safety Net (Resolution 604-I-17); Identification and Reduction of Physician Demoralization (Resolution 605-I-17)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, "Physician Burnout and Wellness Challenges," 604-I-17, "Physician and Physician Assistant Safety Net," and 605-I-17, "Identification and Reduction of Physician Demoralization") with shared components of a central issue were referred for report back together at the 2018 Annual Meeting and presented in BOT Report 31-A-18. Based on testimony in Reference Committee G asking for further clarifications, BOT 31-A-18 was referred back for a report at the 2019 Annual Meeting. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting, and presents recommendations accordingly.

Resolution 601-I-17, "Physician Burnout and Wellness Challenges," was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, "Physician and Physician Assistant Safety Net," was introduced by the Oregon Delegation and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, "Identification and Reduction of Physician Demoralization," was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.

BACKGROUND

Today's physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, and feeling professionally under-valued and overburdened by an ever-changing health care system.[1-3] Forty-four percent of practicing physicians report experiencing at least one symptom of burnout, compared to 54 percent in 2014 and 45 percent in 2011.[4] Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care quality will decline and patient safety will suffer.[5] Physician suicide rates have been found to be historically higher than the general population.[6] Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. Resources such as safety nets and hotlines are available for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

The AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA's ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, "Programs on Managing Physician Stress and Burnout"). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, "Physician Health & Wellness"). In recognizing the importance of access to health and wellness-focused resources, AMA policy encourages employers to provide, and employees to participate in, programs on health awareness, safety and the use of health care benefit packages (Policy H-170.986, "Health Information and Education"). The AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, "Physician Health Programs").

Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate its members about the availability of services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. The AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, "Educating Physicians About Physician Health Programs"). The AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness.

The AMA recognizes physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients' well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, "Physician Responsibilities to Impaired Colleagues"). AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. In the same policy, the AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, "Physician Impairment").

Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. The AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. The AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. The AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. The AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians").

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. The AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment and prevention of burnout) through appropriate media outlets. In addition, the AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, the AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and

changes in accreditation requirements (Policy D-310.968, "Physician and Medical Student Burnout").

DISCUSSION

The AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional Satisfaction.[7] This is evidenced by AMA policy supporting the Triple Aim and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, "Support for the Quadruple Aim"). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout.

The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy.[8] This seminal work informed subsequent initiatives and a long-term strategy for AMA's Professional Satisfaction and Practice Sustainability (PS2) unit. This dedicated AMA unit is focused on institutional and system-level solutions that aim to resolve root causes of burnout and demoralization, rather than solely focusing on improving individual resilience to alleviate symptoms experienced by dealing with a dysfunctional health system.

Through the PS2 unit, the AMA supports and carries out research efforts aimed at understanding and identifying solutions to the system-level issues that lead to physician demoralization and burnout. In 2017 and 2018 the AMA partnered with leading academic institutions to conduct follow-up research to its 2011 and 2014 national studies on physician burnout and satisfaction, seeking to learn if the rates of burnout have changed over the past 7 years.[9] The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physicians' workday.[10] The AMA has also completed significant research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.[11, 12] Furthermore, the AMA has researched the impacts of physician burnout, including the effects on a physician's innate sense of calling[13] and implications for the physician workforce.[14] All of this research has been published in leading peer-reviewed journals to build the evidence base for the factors that cause physician dissatisfaction and burnout and their impacts. This body of knowledge has been a powerful tool for advocating to legislators, regulators, and industry executives to make improvements to address the issues that cause physician dissatisfaction.

The AMA continues to convene members of the research community at the bi-annual American Conference on Physician Health and International Conference on Physician Health. To provide hands-on, real-world demonstration of practice-level solutions, the AMA hosts boot camps that help physicians learn how to plan and implement effective strategies to improve their practice to reduce the amount of time they spend on administrative and clerical work, ultimately improving physician satisfaction and reducing reports of burnout.

A number of key accomplishments and offerings have been realized through AMA's launch of the free, online STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their memberships in various forums. In addition, the AMA has partnered with health systems, large practices, state

medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment. The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for "Supportive Work Environment" and "Work Pace and EMR Frustration." In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

The AMA is also developing the AMA Practice Transformation Initiative: Solutions to Increase Joy in Medicine. This initiative will support research to advance evidence-based solutions and engage health care leaders to improve joy in medicine through the use of validated assessment tools, a centralized, integrated data lab, grant-funded practice science research, and field-tested information dissemination and implementation support. It will build the evidence base for private and public investment in clinician well-being as a means of achieving the Quadruple Aim. The focus of the AMA Practice Transformation Initiative is distinct from and complementary to other national initiatives addressing clinician well-being. For example, the work of the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience is focused on building awareness. This AMA initiative will move beyond awareness to filling the knowledge gaps that exist regarding effective systemic interventions to reduce burnout. In a similar manner, the 1999 Institute of Medicine (now renamed the National Academy of Medicine) report "To Err is Human" raised awareness of patient safety issues. It was then up to other organizations to build further evidence and disseminate effective interventions. In this vein, the AMA Practice Transformation Initiative will be positioned to lead the medical community in building momentum and disseminating evidence-based solutions to reduce burnout and improve satisfaction. This effort is currently in the pilot phase with broader expansion planned for mid- to late-2019.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. In addition to HOD policy that affirms the importance of physician health and education about wellness, the AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The Physicians Foundation funded an effort to develop a manual on how to create a Physician Wellness Program (PWP) for medical societies called LifeBridge. In addition to a toolkit, the manual includes research and background supporting the need for such a program. Having medical societies provide local, onsite counseling is the cornerstone of the program, in addition to including other aspects of physician wellness resources such as professional coaching, educational topics, resource centers, and ways to address health system barriers and advocate for employer change. With this resource, numerous state and county medical societies are developing and launching physician wellness programs with in-person support. Hundreds of physicians have accessed these resources to date.

The mission of the Federation of State Physician Health Programs (FSPHP) is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care. One of FSPHP's top priorities is the development of a Performance Enhancement and Effectiveness Review program called PEER™. The goal of PEER is to empower physician health programs (PHPs) to optimize effectiveness. At the same time, they are developing a Provider Accreditation program that will accredit specialized treatment centers and other providers in the care of physicians and other safety-sensitive professionals. These programs will ensure quality care

and ensure PHPs select providers that have proven compliance with objective standards. The AMA has provided grant funding toward this new effort and has provided a designee to serve on FSPHP's Accreditation Review Council (ARC) that will oversee the strategy and policies of the developing PEER program.

Concerns have been raised that physicians who access wellness programs may be stigmatized if they report feelings of demoralization or burnout. This could subject a physician to loss of employment or to state medical licensing board actions, including loss of license. It is imperative that strategies be developed by state medical associations to encourage physicians to participate in health programs without fear of loss of license or employment. Assuring that de-stigmatization of physician burnout is addressed at the local, state and national levels is an important first step in ensuring those who need support can receive it without fear of adverse consequences.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability (PS2) strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published numerous resources to help physicians manage stress and prevent and reduce burnout. Since its inception in 2011, the activities have been aided by a PS2 Advisory Committee composed of a diverse membership representing the AMA physician membership as well as the business of medicine. Meeting quarterly, the PS2 Advisory Committee provides strategic insight and direct feedback to the PS2 staff on activities ranging from practice transformation and burnout to digital health, payment and quality. The composition of the PS2 Advisory Committee ensures the committee provides content expertise in the subject matter areas on which the PS2 group focuses.

While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are many national, state and locally operated hotlines available that are open to all individuals regardless of profession. A list of many of these resources is available in the STEPS Forward module "Preventing Physician Distress and Suicide." The AMA is evaluating Employee Assistance Program (EAP) service providers to explore the option of piloting a service to AMA members as a membership benefit. Some EAP services provide participants with 24/7 telephone or video access to qualified and trained counselors, wellness services, and critical incident support. This evaluation is in early stages and a decision to pursue various options will be considered. In addition, the AMA will continue to update the list of available suicide prevention resources in its related STEPS Forward module.

The AMA is also developing a dynamic education module that will help physicians, physicians in training, and medical students learn about the risks of suicide for physicians, identify characteristics to look for in patients who may be at risk of harming themselves, and recognize the warning signs of potential suicide risk in colleagues. The module, to be offered with continuing medical education credit on the AMA's Education Center, will also provide tools and resources to guide learners in supporting patients and colleagues at risk for suicide.

In addition, the AMA regularly reviews and updates relevant modules of the STEPS Forward program and identifies validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. In addition to the "Preventing Physician Distress and Suicide" module, the STEPS Forward platform provides other relevant modules to address

physician well-being, specifically “Improving Physician Resiliency” and “Physician Wellness: Preventing Resident and Fellow Burnout.” In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments provide organizations the option to embed the PHQ-2 Depression Screening Tool. This allows organizations to gain a deeper understanding of those physicians experiencing more severe levels of depression and disinterest and correlate those responses to burnout. The survey also offers a free text section for physicians in need of services to self-identify and receive direct outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

Current efforts and strategic priorities demonstrate that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to increase efficiency and reduce feelings of burnout among physicians. The AMA’s role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA’s current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. Making existing relevant AMA resources available to physicians seeking help can be accomplished and is part of current AMA practices. The AMA will continue to direct physicians to its current resources and those that are being developed by state and county medical associations to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Feedback from the reference committee at A-18 expressed concern about the earlier report’s lack of proposals for prevention and treatment programs to address physician burnout. By its current policies, through the work of AMA business units, and in the Code of Medical Ethics, the AMA recognizes the importance of programs that prevent and treat stress, depression and other conditions that can lead to burnout. We also realize that the AMA is not a direct provider of health care services; however, the AMA supports and will continue to encourage the development of and participation in programs to assist physicians in early identification and management of stress, burnout and demoralization.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that “burnout” is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of “burnout,” there was no consensus on what that term should be. The AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies. The term “burnout” is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term “burnout” is used broadly, this allows for many variations in the interpretation of its meaning. The AMA does not define the term “burnout” as an individual “resilience deficiency” or character flaw.

The AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. In other words, physician burnout is a symptom of system dysfunction. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.

The AMA has numerous efforts underway to address the system-driven sources of physician demoralization and burnout, such as the increasing volume of administrative requirements like quality reporting and prior authorization, the lack of transparency and interoperability with EHRs, and the complex and ever-changing payment environment. The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state and specialty medical societies, national provider associations and patient representatives to develop a set of Prior Authorization Principles. The AMA has used these principles to spur conversations with health plans about "right-sizing" prior authorization programs. One outcome of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including advancing automation to improve transparency and efficiency. The AMA, in addition to providing an evidence-base demonstrating the need for prior authorization reform, offers multiple resources to help physicians understand prior authorization laws and improve processes within the practice.

It is well-documented that the use of EHRs is a source of dissatisfaction for physicians. The AMA's research includes multiple time-motion studies to determine how much and in what ways physicians spend time completing tasks in their EHRs. This research demonstrates evidence highlighting the need for system-level changes in the demands placed on the EHR as a tool for reporting and patient care. The AMA has also published eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients. If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care. Multiple collaborations are in place to help foster better EHR design and innovative HIT solutions to help make the EHR user experience better and more efficient. The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners and Medstar Health's National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA's Physician Innovation Network is connecting physicians and health care technology entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market. Finally, the AMA is working with other high-profile stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification framework which will help catalyze an industry wide shift to higher-quality EHR systems that enable better, more efficient use.

Another source of discontent for physicians are the myriad changes in payment models and quality reporting requirements facing practices. The AMA recently published a follow-up study to its 2014-2015 RAND research on the effects of payment models on physician practices in the U.S. The findings of the 2017-2018 study help the AMA, other industry stakeholders, and policymakers understand that the challenges experienced in practice due system complexity continue, and much

improvement is still needed. To help physicians and practices navigate these challenges, particularly those spurred by the MACRA Quality Payment Program, the AMA offers a variety of educational resources and practical tools, including step-by-step tutorials on QPP reporting, a MIPS Action Plan, and several others. Additional resources are in development to help physicians navigate the changing payment system that is increasingly putting an emphasis on cost and quality measurement.

Physicians who work irregular or long hours, or physicians in certain specialties, may experience a lack of work-life balance, which can further exacerbate burnout and professional dissatisfaction.[15] Forty percent of physicians report not feeling that their work schedule leaves enough time for personal and/or family life.[9] Furthermore, female physicians are more likely to be dissatisfied with work-life balance.[15] To help physicians improve work-life balance, the AMA Women Physicians Section is working together with the American Academy of Pediatrics to explore the workforce issues and help physicians find practice options that work best for them and their families. For example, a physician may consider reducing work hours to accommodate their schedule. The AMA provides a self-assessment tool that helps physicians explore work/practice options and address career goals. The AMA hosts a series of educational resources that offer strategies on how to increase practice efficiency, understand physician burnout and how to address it, as well as develop a culture that supports physician well-being. Examples of education include online CME modules: "Creating the Organizational Foundation for Joy in Medicine™: Organizational changes lead to physician satisfaction," "Creating Strong Team Culture: Evaluate and improve team culture in your practice," "Physician Wellness: Preventing Resident and Fellow Burnout," "Preventing Physician Burnout: Improve patient satisfaction, quality outcomes and provider recruitment and retention," and "Improving Physician Resiliency: Foster self-care and protect against burnout."

In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA's Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. To date, numerous health systems, physician practices, and residency programs have completed AMA's burnout measurement program. This program will continue to be marketed and scaled to expand the use of measuring physician dissatisfaction and burnout. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to addressing the issue of burnout and enhancing joy in practice for physicians, residents and medical students. The AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through its existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATIONS

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    1. H-170.986, "Health Information and Education"
    2. H-405.957, "Programs on Managing Physician Stress and Burnout;"
    3. H-405.961, "Physician Health Programs;"
    4. D-405.990, "Educating Physicians About Physician Health Programs;"
    5. H-95.955, "Physician Impairment;" and
    6. H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." (Reaffirm HOD Policy)

2. That our American Medical Association amend existing Policy H-405.961, "Physician Health Programs," to add the following directive (Modify Current HOD Policy):

    1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
    2. Our AMA encourages state medical societies to collaborate with the state medical boards to a) develop strategies to destigmatize physician burnout, and b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

3. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives (Modify Current HOD Policy):

    1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

    2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

    3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

    4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

    5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

    6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Fiscal note: Minimal – Less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-19

Subject:	Non-Payment and Audit Takebacks by CMS (Resolution 704-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 704-A-18, "Non-Payment and Audit Takebacks by CMS," for report back at the 2019 Annual Meeting. This resolution was introduced by the New York Delegation and asked that:

> Our American Medical Association (AMA) seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies;
>
> Our AMA seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies; and
>
> Our AMA seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies.

This report discusses the broader concept of medical record documentation, the administrative burden of documentation, and related AMA policy.

BACKGROUND

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record is a chronological reflection of the care of the patient and is an important element contributing to the quality of care.[1] In addition, the medical record documentation serves as evidence of the provision of services, who provided the care, the medical necessity, and the quality of care. The original medical documentation must be filed in the patient's medical record at that facility. The documentation of medical record can also be used by payers and oversight entities to deny or recoup payment for inadvertent mistakes.

While Congress, federal agencies, and states have made unprecedented investments in improving oversight and program integrity, significant challenges remain. Efforts to fight health care fraud or identify areas of waste or abuse have a tangible impact on physician practices. To comply with the federal program integrity and documentation requirements, physicians proactively conduct internal audits and adopt compliance programs at their own cost.

Broad-brush requirements that impose burdens on all physicians, rather than focusing on those providers who have demonstrated a propensity to commit fraud or abuse, inequitably affect

physicians and providers who are good actors, and result in unnecessary costs to the health care system. This fact is especially true in pre- and post-payment review. The number of reviews and types of reviewers are confusing, add unwarranted physician burden and unnecessary costs, and disrupt and distract from delivering patient-centered care.[2] Furthermore, some contractors audit and attempt to recoup against services that Medicare does not require, do not adhere to CMS requirements surrounding the approval of Local Coverage Determinations (LCD), or are for minor, clinically insignificant errors.

The regulatory burden placed on physicians is also a major component of physician burnout. Physicians often must spend too much of their time on administrative tasks rather than providing care to patients. The evolving health care system needs easier enrollment, more rational program integrity rules, and fewer reporting requirements.

RELATED POLICIES

Our AMA has extensive policy opposing the imposition of inappropriate actions for minor documentation errors by the federal government and private payers. Physicians must be protected from allegations of fraud, waste and abuse, and penalties and sanctions due to the differences in interpretation and or inadvertent errors in coding.[3] Moreover, AMA policy directs our AMA to oppose efforts to punish or harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services.[4]

AMA policy also already directs our AMA to pursue legislative, regulatory, or other avenues to eliminate fines for inadvertent Medicare billing errors[5] and to remove a physician from a potential review if there is proof that the error is only related to a clerical mistake.[6] It is also AMA policy that insufficient documentation or inadvertent errors in the patient record do not constitute fraud or abuse[7] and that there should be no medical documentation requirements for the inclusion of any items unrelated to the care provided.[8] Furthermore, our AMA policy supports the elimination or improvement on the use of extrapolation in Medicare post-payment audits[9] including RAC audits.[10]

DISCUSSION

Our AMA has strong existing policy (see appendix) regarding the opposing of claim nonpayment for inadvertent, unintentional, or clerical errors. Our AMA is already working with the federal government to reduce administrative burden through regulatory relief efforts including areas involving inadvertent, unintentional, or clerical errors in documentation. Moreover, our AMA has stated multiple times that unnecessary administrative tasks undercut the patient-physician relationship.[11] For example, studies have documented lower patient satisfaction when physicians spend more time looking at the computer and performing clerical tasks.[12] Moreover, for every hour of face-to-face time with patients, physicians spend nearly two additional hours on administrative tasks throughout the day.[13] The increase in administrative tasks is unsustainable, diverts time and focus away from patient care, and leads to additional stress and burnout among physicians. Furthermore, our AMA has already stated that CMS should review sub-regulatory guidelines, which create additional burdens on physicians, and reduce the number of sub-regulatory guidance documents that are issued.

While our AMA has policies, and has taken action in regard to inadvertent errors, the Board of Trustees believes that AMA policy could be more specific in addressing the concerns surrounding minor wording errors or clinically insignificant inconsistencies and their relationship to potential nonpayment, extrapolation of overpayments, and bundled payment denials. Although the original

resolves of Resolution 704-A-18 call for our AMA to "seek through legislation and/or regulation," the Board of Trustees believes that our AMA should have flexibility in addressing this issue and not be required to only seek reform through legislation or regulation. Instead, in addition to these avenues, our AMA should also be seeking reform through sub-regulatory guidance and other payer policies.

Our AMA believes that eliminating and/or streamlining reporting, monitoring, and documentation requirements will improve the health care delivery system and make the health care system more effective, simple, and accessible. By reducing administrative burden, CMS can support the patient-physician relationship and allow physicians to focus on an individual patient's welfare and, more broadly, on protecting public health.

RECOMMENDATION:

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 704-A-18 and the remainder of the report be filed:

> That our American Medical Association advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

[1] E.g., CMS, *Medicare Learning Network Fact Sheet: Complying with Medical Record Documentation Requirements*, (2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf; MSSNY, *Basics of E/M Coding: A Handbook for Physician Offices* (2009), https://www.mssny.org/Documents/2016/Practice%20Resources/Coding_Handbook.doc_6-16-09-Revised_8-14-09-add.pdf.
[2] Physicians face pre-payment and postpayment scrutiny from a variety of government entities and contractors including CMS, Medicare Administrative Contractors (MAC), Recovery Audit Contractors (RAC), Unified Program Integrity Contractors (UPIC) (combining program safeguard, zone program integrity, and Medicaid integrity contractors), Quality Improvement Organizations (QIO), Comprehensive Error Rate Testing (CERT), and Supplemental Medical Review Contractors (SMRC).
[3] Fraud and Abuse Within the Medicare System, (H-175.981).
[4] Kennedy-Kassebaum: Fraud and Abuse, H-175.985.
[5] Due Process for Physicians, H-175.982.
[6] Expedited Review for Clerical Errors on Medicare Enrollment Applications, D-330.905.
[7] Medicare Guidelines for Evaluation and Management Codes, H-70.952.
[8] *Id.*
[9] Medicare Prepayment and Postpayment Audits, H-330.921; Medical Office Screens, H-335.981.
[10] Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991.
[11] E.g., AMA Letter to CMS, *Medicare and Medicaid Programs: Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)* (Nov. 19, 2018).
[12] Street RL et al., Provider Interaction with the Electronic Health Record: The Effects on Patient-Centered Communication in Medical Encounters. Patient Educ. Couns., 2014; Kazmi Z, Effects of Exam Room EHR Use on Doctor-Patient Communication: A Systematic Literature Review. Inform Prim Care, 2013; Farber NJ et al., EHR Use and Patient Satisfaction: What We Learned. J Fam Pract 2015.
[13] Colligan L, Sinsky C, Goeders L, Schmidt-Bowman M, Tutty M. *Sources of physician satisfaction and dissatisfaction and review of administrative tasks in ambulatory practice: A qualitative analysis of physician and staff interviews*, Oct. 2016.

APPENDIX: AMA POLICIES

Policy H-175.981, "Fraud and Abuse Within the Medicare System"
(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.
(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies.
(3) The burden of proof for proving fraud and abuse should rest with the government at all times.
(4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation.
(5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens.
Sub. Res. 801, A-98 Reaffirmed: Res. 804, I-98 Reaffirmed: BOT Rep. 6, A-00 Reaffirmation I-01 Modified: CMS Rep. 7, A-11

Policy H-175.982, "Due Process for Physicians"
It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations.
Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following:
(1) Patient care in the physician's office must not be interrupted during the course of the audit;
(2) Patient ingress and egress must not be hindered during the course of an audit;
(3) Normal telephonic communication must not be interrupted during the course of an audit; and
(4) Normal routine of physician's care of patients in hospital or at home must not be interrupted.
AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors.
Sub. Res. 229, I-97 Reaffirmation A-99 Reaffirmation I-00 Reaffirmation I-01 Reaffirmed: Res. 12, A-06 Reaffirmation I-07 Reaffirmed: BOT Rep. 22, A-17

Policy H-175.985, "Kennedy-Kassebaum: Fraud and Abuse"
Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;
(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of "willfully and knowingly" to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;
(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;
(5) continues its efforts to educate the entire Federation about the AMA's successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be

prosecuted or fined for inadvertent billing errors, absent an intent to "knowingly and willfully" defraud;
(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and
(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.
Sub. Res. 222, A-97 Appended: Res. 202, I-98 Reaffirmation A-99 Reaffirmation A-01 Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, A-12

Policy H-175.979, "Medicare "Fraud and Abuse" Update"
Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors.
BOT Rep. 34, I-98 Reaffirmation A-99 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation I-01 Reaffirmed: BOT Rep. 22, A-11

Policy H-70.952, "Medicare Guidelines for Evaluation and Management Codes"
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services;
(2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse;
(3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians;
(4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS);
(5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines,
(6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS,
(7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;
(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and
(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.
Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10

Policy D-330.905, "Expedited Review for Clerical Errors on Medicare Enrollment Applications"
1. Our AMA will urge the Centers for Medicare and Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges.
2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake.

3. Our AMA will urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.
Res. 222, A-16

Policy D-320.991, "Creating a Fair and Balanced Medicare and Medicaid RAC Program"
1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.
2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.
3. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.

4. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.
5. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.
6. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.
7. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.
Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I13; Reaffirmed: Res. 223, I-13

REPORT 32 OF THE BOARD OF TRUSTEES (A-19)
Impact of High Capital Costs of Hospital EHRs on the Medical Staff
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention. This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

Implementing or upgrading an Electronic Health Record (EHR) in a medical practice, while beneficial in many ways, comes with a variety of costs. These costs include financial, productivity, workforce/personnel, and clinician and patient satisfaction. Long-term, these costs can all have effects on a health system's medical staff/workforce. These impacts, and the long-term economic and financial costs, are not widely studied or discussed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-19

Subject:	Impact of High Capital Costs of Hospital EHRs on the Medical Staff
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention.

This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

BACKGROUND

Electronic health records (EHRs) are an integral part of the vast majority of health care delivery in the United States. In 2017, 99 percent of large, 97 percent of medium, and 93 percent of small rural non-federal hospitals had a certified EHR product in operation.[1] In 2015, the most recent year for which data could be found, 84 percent of non-federal acute care hospitals had at least a basic EHR in operation, and 87 percent of office-based physicians were using an EHR.[2] The benefits of EHR use are well-documented, however, so are the growing concerns with the amount of time and types of tasks required in using an EHR in practice.[3, 4] There is also evidence showing the often-burdensome financial investment that implementing and maintaining an EHR system requires. Although there are several studies quantifying the financial investment, the reported costs of EHR implementation vary greatly across studies,[5, 6] owing most likely to differences in geographic locations, practice size and type, and EHR type. One study estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year.[7] In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.[8] The differences in practice size and type, EHR type, health information technology (HIT) budgets, specialty, and rural/urban location, make it difficult to accurately quantify costs that are representative across health care practices in the U.S. In addition, the Centers for Medicare & Medicaid Services (CMS) has not updated the practice expense component of the resource-based relative value scale (RBRVS) physician fee schedule in nearly a decade, compounding the lack of valid comparisons and the potential underpayment to physicians for expenses required to maintain a current EHR system. Notwithstanding the challenges in quantifying costs, it is important to consider and understand the long-term impacts of the financial commitment required to implement or upgrade an EHR, including the effects on the physician and clinician workforce.

The financial costs of implementing an EHR system comprise many factors, including software licensing, projected maintenance, fees, and costs for initial and ongoing training and labor. Some hospitals include the salaries of existing HIT staff in their cost estimates. Others may include the costs of hardware such as new computers, tablets or other devices. These costs can add up to millions, and even billions of dollars for the largest purchasers.[9] Additional costs arise when expenses exceed budgets and when organizations invest in upgrading or optimizing their original EHR system. Other costs, sometimes attributable to EHR implementation, can occur in the form of workforce attrition that happens when organizations cut staff to reduce costs or physicians reduce work hours or leave practice due to frustrations with administrative burden created by EHRs. Despite these challenges, EHRs will continue to be a principal component of health care delivery in the U.S. However, for the technology to be a viable and sustainable solution for practices of all sizes and types, it will be important to know the potential long-term effects the high implementation, optimization, and maintenance costs will have on the ability to sustain existing medical staff and recruit new staff to meet the growing demand of patients' needs.

AMA POLICY

The AMA has extensive policy supporting the use of EHRs and encouraging stakeholders to implement policies, technology improvements, and utilization standards to minimize the financial burden and maximize efficiency and safety in the use of EHRs.

The AMA is committed to working with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure, so that the financial burden on physicians is not disproportionate when they implement health care technologies in their offices. The AMA also continues to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining EHRs (Policy D-478.996, "Information Technology Standards and Costs"). The AMA is working with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production (Policy D-478.973, "Principles for Hospital Sponsored Electronic Health Records").

The AMA supports the drive for innovation in the use of EHRs to develop best practices concerning key EHR features that can improve the quality, safety, and efficiency of health care (Policy D-478.976, "Innovation to Improve Usability and Decrease Costs of EHR Systems for Physicians"). In addition, the AMA advocates for 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. The AMA works 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 (Policy D-478.995, "National Health Information Technology").

It is AMA policy that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules, which if represented appropriately would help offset these costs for many practices (Policy H-478.981, "Health Information Technology Principles"). Furthermore, the AMA advocates for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) EHRs and continuously evaluates and monitors the cost to physicians and their practices of maintaining and upgrading EHRs (Policy D-478.975, "Maintenance Payments for Electronic Health Records").

DISCUSSION

Costs of implementing or upgrading an EHR system

The costs associated with implementing and/or optimizing an EHR system have been shown to vary significantly across practices and organizations. This is based on a variety of factors, including but not limited to, practice type and size, infrastructure needs, staffing resources, and maintenance fees. Due to the variability of factors, precise costs are difficult to confirm across practice settings.

Several studies and reports have endeavored to document and estimate the immediate and ongoing costs of EHR implementation. One study estimated EHR implementation for a solo physician in practice to cost $163,765, inclusive of labor and hardware costs. In the same study, it was estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year.[7] In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.[8]

In conjunction with evaluating the costs of implementation, several studies have also described the cost-benefit analysis of EHRs in various practice settings. A 2003 study of EHR implementation in a primary care practice estimated the net benefit from using an electronic medical record for a five-year period was $86,400 per provider. Benefits resulted primarily from savings in drug expenditures, improved utilization of radiology tests, better capture of charges, and decreased billing errors. Using a five-way sensitivity analysis that accounted for variables such as proportion of capitated patients, patient panel size, and software and hardware costs, this study showed results ranging from a $2,300 net cost to a $330,900 net benefit to the organization. However, among fee-for-service patients, a large portion of the savings from improved utilization may accrue to the payer instead of the provider organization.[10] This study was completed using data from an internally developed EMR at Partners HealthCare, an integrated network formed by Brigham and Women's Hospital and Massachusetts General Hospital.

Another study found that implementation of EHRs in solo or small practices incurred initial costs of approximately $44,000 per FTE provider per year, including software, hardware and lost revenue from reduced productivity. Ongoing costs were estimated at $8,500 per FTE provider per year, including software and hardware maintenance or replacement, and support staff. This study also found the average practice paid for its initial and cumulative ongoing EHR costs within two and a half years, and began to see more than $23,000 in net benefits per FTE provider per year. Also of note, participants in this evaluation reported that providers worked longer hours for about four months after implementation, as they became more familiar with the system.[11]

A 2013 projection of return on investment (ROI) five years after an EHR pilot predicted each physician would lose nearly $44,000 and only 27% of practices surveyed would achieve a positive ROI. An additional 14% would experience a net gain if they received the federal meaningful use incentive. This analysis revealed the largest difference between practices with a positive return on investment and those with a negative return would be the extent to which they used their EHRs to increase revenue, primarily by seeing more patients per day or by improved billing that resulted in fewer rejected claims and more accurate coding.[12]

A 2014 ROI analysis found that primary care practices recovered their EHR investments within an average period of 10 months. An observed increase in the number of active patients, the increase in the active-patients-to-clinician-FTE ratio, and the increase in the clinic net revenue are positively

associated with the EHR implementation, likely contributing substantially to the 10-month average break-even point.[13]

In addition to initial implementation costs, upgrades and optimizations require significant resources, but can help the organization realize cost and time efficiencies. In 2017, 38 percent of health care CIOs indicated "EMR optimization" as their organization's top item planned for capital investment through 2020.[14] A 2018 case study at a Colorado hospital employed an optimization strategy that saved them between $300,000 and $500,000 per year, in addition to a 53 percent increase in cash collections since go-live, a 15 percent decrease in days in accounts receivable, assistance from time-saving tools that automatically track changes to payer rules, authorization management services that free up staff to take on high-value work, and reduced operating costs with transparent pricing that includes upgrades and interfaces.[15]

Furthermore, to encourage organizations to adopt HIT technology and specifically EHR systems, the federal government provided incentives to those providers who met "meaningful use" standards through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As of October 2018, CMS reported payments of $38.4 billion to almost 550,000 Medicare and Medicaid providers, or approximately $65,000 per provider. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunset the meaningful use program for physicians participating in Medicare. Physicians and hospitals participating in CMS programs now fall under Promoting Interoperability (PI) program requirements.[16] The Quality Payment Program, which replaced the Medicare meaningful use program, sunset the HITECH Act meaningful use incentives. However, PI participants in Medicaid are still eligible for incentive payments through 2021. It should be noted, however, that practices that did not implement an EHR system or were not eligible for the meaningful use program did not receive incentive payments.

Staff/workforce reductions resulting from EHR investment

Many healthcare organizations have reported reductions in workforce over recent years. The reasons for staff reductions vary from lowered reimbursements, realignment towards value-based care, optimizing operational efficiency, and EHR-related costs. Organizations citing workforce reductions related to excessive EHR costs have widely reported layoffs in the areas of general operations, administration, revenue cycle and information technology, not in the positions of direct patient care, such as physicians, advanced practice providers and nursing.[17] In a recent statement from Tenet Healthcare, leadership reported the intent to offshore more than 1,000 jobs, likely in the area of corporate functions. Tenet leadership also expressly stated direct patient care employees, such as physicians and nurses, would not be affected by the change.[18]

Reports of workforce reduction or job outsourcing specifically due to investments in EHR technology exist, but are few. For example, in 2015 Lahey Health in Massachusetts lost $21 million due to both lost business and expenses related to EHR implementation. The shortfall prompted Lahey to lay off 130 people, which their CEO attributed partly to unplanned training expenses connected to the EHR implementation.[19] Also in 2015, Southcoast Hospital reduced its workforce by one percent after expenses related to their EHR implementation exceeded what they budgeted.[20]

At the end of 2015, Brigham and Women's Hospital reported lower financial gains than they had originally anticipated with their EHR implementation after falling $53 million short of the $121 million expectation. These losses led to the subsequent elimination of 80 open positions and 20 staff members. Hospital president Betsy Nabel, MD, credited this in part to reduced reimbursements from payers, high labor expenses among a largely unionized workforce, and high

capital costs, including those related to new facilities and their Epic implementation.[21] The hospital budgeted $47 million for its implementation, but faced $27 million in unexpected costs.[22] In 2017, even while finances were improving, Brigham and Women's was still facing a shortfall, forcing them to commit to a $50 million reduction in operating expenses, including offering a buyout to more than 1,000 senior employees, including nursing staff.[23]

In 2017, MD Anderson Cancer Center cut between 800 and 900 administrative positions after experiencing significant losses after EHR implementation. MD Anderson also reported decreased patient revenues resulting from EHR implementation but did not provide details on how the EHR affected patient revenue.[24] However, they reported operating margins were net positive at fiscal year-end 2017.[25] Wake Forest Baptist Medical Center and Moses Cone Memorial Hospital in North Carolina have both experienced downgraded bond ratings and significant operating losses after implementing EHR systems. They have both also cut staff to make up for these losses.[26]

EHR implementation was undoubtedly a major factor in the financial circumstances that prompted workforce reductions for these organizations. No one factor can be considered the sole catalyst, however, as other significant costs, such as investments in new facilities, acquisition of other practices, losses on investments, changing reimbursement rates, and increased operational costs contributed to the budget holes that forced these hospitals to take cost-saving measures.[27] It is also important to consider that hospitals and health systems reduce workforce for many reasons, including forces entirely separate from EHR implementation, such as changing patient population, specialty mix, or community needs.

Considerable costs, unbudgeted expenses, unforeseen training needs, and lost productivity due to learning curves and unexpected downtime, are all known risks of implementing any new or upgraded EHR.[28] Despite these accounts of losses and financial distress, some organizations implement EHRs without issue and the long-term gains outweigh the short term financial losses. It is also of note that the cases described above all involve the same EHR vendor product, therefore generalizing these adverse experiences to all EHRs is not advised.

In addition to staff/workforce reductions driven by budgetary reasons, EHR implementation is transforming the personnel needs and roles for healthcare organizations. A 2016 publication from the North Carolina Medical Journal highlights the need for new jobs to assist before, during, and after EHR implementation, such as technical software support staff, medical scribe specialists, health care quality improvement specialists, and health care data scientists.[29] The most common areas of staff reduction due to EHR implementation are in the areas of medical records, transcription, and billing by replacing paper-related processes.[29, 30]

An indirect cost of EHR implementation can be seen in the effects EHRs have on physicians in practice, including increasing administrative burden, reducing face-to-face time with patients, and even prompting reduction in work hours or leaving medicine altogether.[31] Nearly 40 percent of doctors list EHR design as one of the two things they find least satisfying about their jobs. Fifty-six percent say the requirement has reduced efficiency and 66 percent report EHR use has reduced the amount of time they spend with patients.[32] In a 2017 survey, nearly one in five physicians indicated they planned to reduce work hours within the following year. Dissatisfaction with the EHR was an independent predictor of a physician's intent to leave practice or reduce clinical hours.[31]

Effects of EHR investment on the financial state of hospitals

Implementing an EHR system is a significant undertaking for any practice or health care organization. Adequate implementation can be costly and time consuming, resulting in many organizations assuming a financial loss for a duration of time, a factor to be included in the capital planning and budgetary process. Many eligible providers received incentive payments for the adoption and use of EHRs,[16] and the majority of eligible hospitals have demonstrated meaningful use of certified HIT through participation in the EHR incentive program.[1]

Common drivers and challenges contribute to the financial impact of EHR implementation. During the implementation process, an increase in overall operational expenses occurs due to training of personnel and the need for additional staff, consultants, and upfront product purchases. During this time, the organization simultaneously experiences a reduction in productivity resulting in decreased patient revenue. In addition to these two factors, some organizations discover they underestimated the full costs of EHR implementation. For example, primary budgeting may only account for the cost reported by the vendor, and the organization does not consider the expenses of staff, training, infrastructure costs, and ongoing maintenance, resulting in significant unexpected costs.

Other areas of additional or unexpected costs include compliance with regulatory requirements, credit challenges, and vendor deficiencies. With the introduction of meaningful use requirements and government incentives, additional costs are often incurred to comply with regulatory requirements.[33] Some hospitals have reported credit challenges in having adequate financial reserves to support the initial capital investment required for implementing an EHR platform.[34] Other organizations have cited additional costs due to vendor shortcomings. For example, Mountainview Medical Center in White Sulphur Springs, Montana filed a lawsuit against NextGen for failing to install a compliant system on time.[34]

As technology advances and regulatory requirements for data collection evolve, EHR implementation and optimization projects are becoming more comprehensive. As a result, many organizations have reported initial financial losses. However, recovery of net operating income and a return to prior productivity levels occur within a short period of time. In 2015 and 2016, Partners HealthCare, the site of the 2003 study previously discussed,[10] implemented a new EHR system. Partners HealthCare reported a decline of $74.1 million in operating income for the last quarter of 2015 compared to the same quarter the prior year, due in part to the organization's EHR implementation. By the second quarter of 2016, leadership reported gains in operating income, despite simultaneously experiencing costs of $18 million in EHR-related upgrades and expenses.[35]

In the first quarter of 2016, Allegheny Health Network reported an operating loss of $17.8 million due to EHR implementation expenses, $8.1 million more than the same period in the prior year. In planning, the health system projected $9.4 million in net losses for the first quarter of the year, yet reported $20.6 million. Leadership stated that in addition to decreased patient volumes, much of the costs were attributed to a one-time investment in the EHR system.[35]

While there is evidence that practices have incurred financial losses during EHR implementation and optimization,[35] an extensive literature search does not identify an instance of any practice or organization closing or changing their physician recruitment and retention practices specifically due to exorbitant HIT/EHR costs. In addition, there is no requirement for medical staffs to report to a state or national database why a medical staff member decides to resign, nor is there a requirement to report the number of medical staff members and their membership status (e.g., active, courtesy, consulting, emeritus making it further difficult to quantify such effects.

Long-term economic impacts

There are very few studies available about the long-term economic impacts or effects of EHR implementation. One 2015 study attempted to examine financial and clinical work day productivity outcomes associated with the use of an EHR over nine years. The difference in net clinical revenue per provider per year did not change significantly after EHR implementation. Charge capture, the proportion of higher- and lower-level visit codes for new and established patients, and patient visits per provider remained stable, and a total savings of $188,951 in transcription costs occurred over a 4-year time period post-EHR implementation.[36] Another 2014 study evaluated the long-term financial impact of EHR implementation in ambulatory practice. Practice productivity was tracked over two years post-EHR implementation and demonstrated that the implementation was associated with increased revenue, even after accounting for observed reduction in the number of patient visits.[37] The AMA inquired with leadership at the American Hospital Association to determine if they had additional research, content, or resources on the subject of EHR cost impacts on hospitals and medical staffs, and they indicated they do not currently have any materials or resources available.

CONCLUSION

It is evident from the literature that the costs, break-even point, and ROI all vary dramatically depending on practice type, size, patient panel, specialty, and location. Given these disparate representations, and the limited amount of recent, rigorous long-term study, it is difficult to establish a universal ROI-focused narrative that makes a case that EHRs are either a wise or poor long-term investment for hospitals or health systems, or any practice type. While there is anecdotal evidence of physicians retiring early due to the implementation costs of EHR's there is little to no data available to assert that investments in EHR technology will lead to subsequent reductions in medical staff. Although EHR investments have contributed to temporary financial losses for some organizations, there are no reports of hospitals or health systems forced to make sweeping reductions in medical staff or completely closing explicitly due to investments in EHR technology. One could speculate that organizations cutting or outsourcing non-direct patient care staff may not be in a financial position to add more physicians to the staff, however there is no data to support this. Although the impacts of staffing cuts inevitably affect care teams and patients, there is little to no evidence that physicians have been included in the groups of workers laid off by organizations that have made cuts.

A common theme throughout the available literature on cost-benefit analysis is that realizing the benefits and achieving a positive ROI depend heavily on the engagement with and optimization of the EHR as a tool for efficiency and process change. Simply installing the system without proper training and feature customization will slow productivity and create new problems. Partial implementation of an EHR, i.e., the continued use of paper for some record keeping, will inhibit the benefits of implementing an EHR and reduce the total return on investment. Organizational policies that promote EHR-enabled changes, such as EHR-supported clinic workflow, along with more thorough research and planning for the implementation process, could facilitate the realization of positive ROI and reduce the potential need for workforce reduction.

RECOMMENDATION

The Board of Trustees recommends that Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," be rescinded as having been fulfilled by this report and that the remainder of this report be filed. (Rescind HOD Policy)

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-19

Subject: Council on Medical Service Sunset Review of 2009 AMA House Policies

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to reestablish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.

- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.

- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.

- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.

- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated. (Directive to Take Action).

Appendix
Recommended Actions on 2009 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
D-165.950	Educating the American People About Health System Reform	Rescind. Superseded by Policy H-165.838.
D-165.994	Status Report on the Uninsured	Retain. Still relevant.
D-165.996	Expanding Patient Choice in the Private Sector	Retain. Still relevant.
D-180.985	Health Plan and Insurer Transparency	Rescind. Superseded by Policy D-155.987.
D-185.988	Assuring Continued Coverage for Patients Transitioning Between Insurance Products	Rescind. Superseded by Policy H-165.838.
D-225.997	Medical Records Signature	Rescind. Superseded by Policy H-225.965.
D-285.995	Coordination of Information on Third Party Relations Activities	Retain. Still relevant.
D-330.924	Reform the Medicare System	Retain-in-part. Policy D-330.937 has been rescinded. Policy should be amended to read: D-330.924 Reform the Medicare System Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), ~~defined contribution (D-330.937),~~ and balance billing (D-380.996, H-385.991, D-390.969).
D-330.930	Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans	Retain-in-part. The AMA completed the investigation into and reported to CMS any insurers claiming to have "deemed" panels of physicians who have agreed to accept Medicare Advantage private fee-for-service plan enrollees. Policy should be amended to read: Our AMA will ~~(1) investigate, and report to the Centers for Medicare and Medicaid Services, any~~

Policy #	Policy Title	Recommended Action and Rationale
		~~insurers claiming to have "deemed" panels of physicians who have agreed to accept Medicare Advantage private fee-for-service (PFFS) plan enrollees;~~ ~~(2)~~ continue its efforts to educate physicians and the general public on the implications of participating in ~~PFFS plans and other~~ programs offered under Medicare Advantage; and ~~(3)~~ educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
D-330.996	Support for an Open Medicare Coverage Process	Retain. Still relevant.
D-385.966	Appropriate Payment for Mandated Benefits	Retain. Still relevant.
D-385.976	Published Reimbursement Schedules by Private Insurers	Retain. Still relevant.
D-390.989	Equal Pay for Equal Work	Retain. Still relevant.
D-390.997	CMS Practice Expense Formula	Retain. Still relevant.
D-400.989	Equal Pay for Equal Work	Retain. Still relevant.
H-110.996	Cost of Prescription Drugs	Rescind. Superseded by Policies H-110.997, H-110.990 and H-110.991.
H-130.939	Emergency Department Readiness to Care for Children	Retain-in-part. Change "~~Guidelines for Care of Children in the Emergency Department~~" to "guidelines for Pediatric Readiness in the Emergency Department" to reflect the title of the revised guidelines.
H-130.940	Emergency Department Boarding and Crowding	Retain. Still relevant.
H-140.920	Socioeconomic Factors Influencing the Patient-Physician Relationship	Retain. Still relevant.
H-155.957	Geographic Variation in Health Care Cost and Utilization	Retain. Still relevant.
H-160.927	Coerced Employment of Physicians	Retain. Still relevant.
H-165.844	Educating the American People About Health System Reform	Retain. Still relevant.
H-165.916	Government Controlled Medicine	Retain. Still relevant.
H-180.950	Gender Rating and Discrimination Based on Prior Cesarean Section	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-180.981	Rating or Rejection of Applicants for Health Policies	Rescind. Superseded by Policies H-165.825, H-165.838 and H-165.856.
H-185.945	Medical Foods	Retain. Still relevant
H-185.946	Gender Rating and Discrimination Based on Prior Cesarean Section	Rescind. Superseded by Policies H-165.838 and H-165.856.
H-185.963	Insurance Coverage for Adults with Childhood Diseases	Retain. Still relevant.
H-185.976	Insurance Discrimination Against Victims of Domestic Violence	Retain. Still relevant.
H-185.989	Continuity of Insurance Coverage	Rescind. Superseded by Policies H-165.838 and H-165.856.
H-190.964	Electronic Claims	Retain. Still relevant.
H-190.994	Misleading Explanation of Benefits Language by Insurance Carriers	Retain. Still relevant.
H-215.963	Increasing Transparency of Hospital Contracts for Clinical and Non-Clinical Services	Retain. Still relevant.
H-215.979	Unilateral Imposition of Employee Status on Physicians by Hospitals	Retain. Still relevant.
H-220.943	Medical Staff Self-Governance	Retain. Still relevant.
H-220.961	Hospital Boards of Trustees	Retain. Still relevant.
H-220.988	Hospital Admitting Privileges	Retain-in-part. Rescind (1) as it is superseded by Policy H-235.963.
H-225.953	Principles for Developing a Sustainable and Successful Hospitalist Program	Retain. Still relevant.
H-225.954	Payment for In-House Coverage	Retain. Still relevant.
H-230.954	Privileging Physicians with Low Volume Hospital Activity	Retain. Still relevant.
H-230.992	Hospital Admitting Privileges	Retain. Still relevant.
H-235.963	Credentialed Physician Membership in Organized Medical Staff	Retain. Still relevant.
H-235.967	Medical Staff Legal Counsel and Conflict of Interest	Retain. Still relevant.
H-235.989	Medical Staff Bylaws	Retain. Still relevant.
H-235.992	Legal Counsel for Medical Staffs	Retain. Still relevant.
H-240.966	Reimbursement to Physicians and Hospitals for Government Mandated Services	Retain. Still relevant.
H-240.996	Cost Shifting	Retain. Still relevant.
H-265.999	Legal Reports on Physician-Hospital Relationships	Retain. Still relevant.
H-280.955	Surveys in Nursing Facilities	Retain. Still relevant.
H-285.912	Web-Based Prior Authorization Process	Rescind. Superseded by Policies D-190.974 and H-320.944.
H-285.926	Clinical and Professional Impacts of Cost Containment Efforts	Retain. Still relevant.
H-285.930	Pharmacy Benefit Risk-Sharing by Physicians	Retain. Still relevant.
H-290.997	Medicaid - Towards Reforming the Program	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-320.983	Mandatory Second Opinion	Rescind. No longer relevant.
H-330.912	Appropriate Medical Coverage for Medicare Beneficiaries	Retain. Still relevant.
H-330.913	Medicare Managed Care Opt Out Rules	Retain-in-part. Change title to read "Medicare Advantage ~~Managed Care~~ Opt Out Rules." Modify policy by replacing "Medicare Managed Care" with "Medicare Advantage."
H-330.916	Legislation for Assuring Equitable Participation of Physicians in Medicare-Sponsored Managed Care Organizations	Retain-in-part. Change title to read "Legislation for Assuring Equitable Participation of Physicians in ~~Medicare-Sponsored Managed Care Organizations~~ Medicare Advantage." Modify policy by replacing "Medicare+Choice" with "Medicare Advantage."
H-330.924	Changes in COBRA Federal Regulations	Retain. Still relevant.
H-330.938	Extension of Medicare Price Controls to the Federal Employees Health Benefit Program	Retain. Still relevant.
H-335.992	Modifying the Medicare Unnecessary Services Program	Retain. Still relevant.
H-335.993	Medicare Part B Appeals - Telephone Hearings	Retain. Still relevant.
H-335.996	Spurious Medical Necessity Denials	Retain. Still relevant.
H-375.967	Supervision and Proctoring by Facility Medical Staff	Retain. Still relevant.
H-375.968	Supervision and Proctoring by Facility Medical Staff	Retain. Still relevant.
H-375.974	Clinical Proctoring	Retain. Still relevant.
H-385.920	Condemnation and Reporting of Unilateral Physician Fee Reduction by Oxford	Rescind. Representatives of AMA, MSSNY, CSMS and MSNJ met with Oxford to address its payment policies including frequently varied co-payments and lack of detail on its EOBs. Oxford agreed to participate in future meetings with MSSNY, CSMS and MSNJ to review the content of its EOBs; take steps to improve the transparency of its electronic and paper remittance process; review its annual co-payment change instructions; share co-payment change information with relevant state medical associations; and, develop FAQs for its web site.

Policy #	Policy Title	Recommended Action and Rationale
H-385.935	Medicare National Physician Payment Schedule	Retain. Still relevant.
H-385.952	Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services	Retain. Still relevant.
H-385.977	Counseling - Serious Medical Problems	Retain. Still relevant.
H-385.998	Reimbursement for Diagnostic or Therapeutic Procedures	Retain. Still relevant.
H-390.848	Medicare Coverage of Avastin for Intravitreal Use	Retain. Still relevant.
H-390.896	Payment for Case Management Services	Rescind. There is an assigned payment schedule for E/M.
H-390.945	Legal Action to Resolve Medicare Reimbursement Disparities	Retain. Still relevant.
H-390.961	Opposition to Mandatory Acceptance of Medicare	Retain. Still relevant.
H-400.952	Consolidation of Medicare Fee Schedule Areas	Retain. Still relevant.
H-400.972	Physician Payment Reform	Retain. Still relevant.
H-400.980	Behavioral Adjustments on Physician Payments	Retain. Still relevant.
H-400.990	Refinement of Medicare Physician Payment System	Retain. Still relevant.
H-406.992	The AMA's Medical Practice Survey Research Program	Retain-in-part. The AMA conducts Physician Practice Benchmark Surveys—which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week—every other year. These surveys do not collect income data. Policy should be amended to read: Our AMA: (1) continues to be the world's leader in obtaining, synthesizing and disseminating information on medical practice to physicians by continually evaluating and considering enhancements to its ~~Socioeconomic Monitoring System data collection program~~ Physician Practice Benchmark Survey; and (2) continues to monitor and study the impact of changes in the socioeconomic environment on physicians and medical practices~~; (3) continues to pursue proactive news management to mitigate negative~~

Policy #	Policy Title	Recommended Action and Rationale
		~~press treatment of physician income data; (4) considers studying the impact of changes in the socioeconomic environment on women, minorities, and physicians in settings not currently covered by the Socioeconomic Monitoring System survey; and (5) will survey separate family practice from general practice physician data~~.
H-425.981	Reimbursement of Screening Bone Densitometry	Retain. Still relevant.
H-510.991	Veterans Administration Health System	Retain. Still relevant.

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Hospital Consolidation
(Resolution 235-A-18)
(Reference Committee G)

EXECUTIVE SUMMARY

Most hospital markets are highly concentrated, largely due to consolidation. This report describes horizontal and vertical hospital consolidation and potential consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options).

Because hospital markets are predominantly local, states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have access to the local market-level data needed to oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers outright, state strategies to address consolidation include all-payer rate setting for hospitals (Maryland, Pennsylvania and Vermont) and the Massachusetts Health Policy Commission, which are discussed in this report.

The Council reviewed an abundance of relevant American Medical Association (AMA) policy and recommends affirming that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

Because antitrust efforts may not be effective in hospital markets that are already highly concentrated, the Council also recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-19

Subject:	Hospital Consolidation (Resolution 235-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 235-A-18, "Hospital Consolidation," which was introduced by the Washington Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 235-A-18 asked that our American Medical Association (AMA) actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets, and study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist.

This report discusses horizontal and vertical hospital consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; highlights the role of states; describes alternative solutions that promote competition and choice in hospital markets; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation in health care markets includes both horizontal and vertical mergers of physicians, hospitals, insurers, pharmaceutical companies, pharmaceutical benefit managers, and other entities. As stated in Council Report 5-A-17, "Hospital Consolidation," the AMA believes that health care entity mergers—including among hospitals—should be examined individually, taking into account the case-specific variables of market power and patient needs. The AMA strongly supports health care market competition as well as vigorous state and federal oversight of health care entity consolidation. Antitrust advocacy for physicians is a longstanding AMA priority, and close monitoring of health care markets is a key aspect of AMA antitrust activity.

Horizontal Hospital Consolidation

Although the AMA's most visible health care consolidation efforts have focused on health insurance markets, the AMA has also analyzed hospital market concentration using 2013 and 2016 data from the American Hospital Association. In a 2018 analysis, the AMA looked at 1,946 hospitals in 363 metropolitan statistical area (MSA)-level markets in 2013 and 2,028 hospitals in 387 MSAs in 2016 and found that, in most markets, hospitals (or systems) have large market shares.[1] In terms of hospital market shares, the AMA found that in 95 percent of MSAs, at least one hospital or hospital system had a market share of 30 percent or greater in both 2013 and 2016. In 2016, 72 percent of MSAs were found to have a single hospital or system with a market share of at least 50 percent, and 40 percent of MSAs had a single hospital or system with a market share of

70 percent or more.[2] The AMA analysis also found that, in 2016, 92 percent of MSA-level markets were highly concentrated, and 75 percent of hospitals were members of hospital systems.[3]

Hospital markets are concentrated largely due to consolidation. There were 1,412 hospital mergers between 1998 and 2015—with 561 reported between 2010 and 2015—and an additional 102 and 115 mergers documented in 2016 and 2017, respectively.[4,5] Eleven of the transactions in 2017 were mega-deals involving sellers with net revenues of $1 billion or more.[6]

There are potential benefits and harms resulting from horizontal hospital consolidation, with savings due to economies of scale and enhanced operational efficiencies cited as potential benefits. Hospitals acquiring market power through mergers may also increase prices for hospital care above competitive levels. Although not all hospital mergers impact competition, research has found that mergers in concentrated markets lead to price increases, and that the increases are significant when close competitors consolidate.[7,8] Studies have found little evidence of quality improvements post-merger, and lower quality in more concentrated hospital markets.[9,10] The evidence is more consistent for markets where prices are administered (e.g., Medicare). In markets where prices are market determined, consolidation can also lead to lower quality, but the evidence is more mixed.[11] Highly concentrated hospital markets may also lessen the practice options available to physicians in communities dominated by large hospital systems.

Vertical Hospital Consolidation

A hospital acquiring a physician practice is an example of vertical hospital consolidation. The AMA closely monitors trends in hospital acquisition of physician practices—which was the focus of Council on Medical Service Report 2-A-15, "Expanding AMA's Position on Healthcare Reform Options,"—via biennial Physician Practice Benchmark Surveys (Benchmark Surveys), which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. In 2018, the share of physicians who worked in practices that were at least partially owned by a hospital was 26.7 percent, up from 25.4 percent in 2016, 25.6 percent in 2014 and 23.4 percent in 2012.[12] The share of physicians who were direct hospital employees in 2018 was 8.0 percent, up from 7.4 percent in 2016, 7.2 percent in 2014 and 5.6 percent in 2012.[13]

Vertical hospital consolidation has been found to increase prices and, in markets where prices are administered (e.g., Medicare), to increase total spending.[14,15] Recent steps taken by the Centers for Medicare & Medicaid Services (CMS) to level the site-of-service playing field between physician offices and off-campus hospital provider-based departments may have diminished a crucial incentive for hospitals to purchase physician practices in the future. For many years, higher payments to hospital outpatient departments likely incentivized the sale of physician practices and ambulatory surgical centers (ASCs) to hospitals because acquired facilities meeting certain criteria (e.g., located within 35 miles of the hospital) were routinely converted to hospital outpatient departments and allowed to charge higher rates for services performed at these off-campus facilities. However, a provision in the Bipartisan Budget Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician practices and ASCs. Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under Medicare's Outpatient Prospective Payment System (OPPS), and instead required to bill under the applicable payment system (Physician Fee Schedule). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a Physician Fee Schedule relativity adjuster that is based on a percentage of the OPPS payment rate. CMS has since extended site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015 that were

previously excepted from the BBA provision.[16] The AMA will continue to monitor the impact of these changes on hospital markets.

PROMOTING COMPETITION AND CHOICE

The AMA is aware of the potential effects of hospital consolidation on physicians and patients, including concerns about the loss of physician autonomy in clinical decision-making and preserving physician leadership in large systems, and also increased hospital prices in concentrated markets. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.[17]

The AMA has long been a strong advocate for competitive health care markets and antitrust relief for physicians, and maintains that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for physicians, maximize their practice options, and protect patient-physician relationships include legislative advocacy; advocacy at the Federal Trade Commission (FTC) and the US Department of Justice (DOJ); and the creation of practical physician resources.

State and federal antitrust enforcement for hospital consolidation has been somewhat limited and has had mixed results over the years, with some successes and also periods of intense merger activity.[18] Many mergers have proceeded unchallenged. Experts have also asserted that in hospital markets that are already highly concentrated, antitrust provides no remedy.[19] Accordingly, in addition to antitrust activities, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need (CON) laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency.

Eliminating State CON Laws: The AMA supports the elimination of state CON laws, which are barriers to market entry that harm competition, and supports state medical associations in their advocacy efforts to repeal them. CON laws require state boards to review all entities seeking to enter a health care market to provide care, including existing facilities seeking to offer new services or services in new locations. Thirty-five states and the District of Columbia currently administer CON programs.[20] As stated in Policy H-205.999, the AMA believes that there is little evidence to suggest that CON programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, AMA policy also opposes CON laws and the extension of CON regulations to private physician offices.

Repealing the Ban on Physician-Owned Hospitals: The AMA strongly advocates that Congress repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansions of already existing physician-owned hospitals. Repealing the ban would allow new entrants into hospital markets, thereby increasing competition. Because physician-owned hospitals have been shown to provide the highest quality of care to patients, limiting their viability reduces access to high-quality care. The AMA firmly believes that physician-owned hospitals should be allowed to compete equally with other hospitals, and that the federal ban restricts competition and choice.

Reducing Administrative Burdens: Physicians are increasingly burdened by administrative tasks that are extremely costly to practices and reduce time with patients, yet increase the work necessary to provide medical services. Examples of these burdens include abiding by state and federal rules and regulations, meeting quality reporting requirements, managing electronic health records, and navigating a plethora of payer protocols and utilization management programs. Utilization management has become so burdensome that in 2018 the average physician reported completing 31 prior authorizations per week, a process that required 14.9 hours of work or the equivalent of two business days.[21] Taken together, these burdens make it difficult for physician practices—particularly smaller practices—to compete, which may lead physicians to consolidate with larger groups or hospitals.[22] The AMA conducts widespread prior authorization advocacy and outreach, including promoting Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, model state legislation, the Prior Authorization Physician Survey, and the AMA Prior Authorization toolkit.

Price Transparency: The lack of complete, accurate and timely information about the cost of health care services prevents health care markets from operating efficiently. Patients are increasingly becoming active consumers of health care services rather than passive recipients of care in a market where price is often unknown until after the service is delivered. The AMA supports price transparency and recognizes that achieving meaningful price transparency may help lower health care costs and empower patients to choose low-cost, high-quality care. The AMA supports measures that expand the availability of health care pricing information, enabling patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

ROLE OF STATES

While it is recognized that most hospital markets are highly concentrated and do not work as well as they could, it is also recognized that hospital markets are local and that states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have better access to the local market-level data needed to oversee and challenge proposed mergers in their states. States can take on mergers themselves or join federal antitrust efforts. Some states have approved mergers but established conditions that must be met, such as requiring merged hospitals to maintain charity care programs or capping price increases for a certain number of years. As discussed previously, states can also reduce barriers to new competitors in hospital markets by eliminating CON laws.

All-Payer Rate Setting for Hospitals (Maryland, Pennsylvania and Vermont)

The approach to fostering competition cited in referred Resolution 235-A-18 is all-payer rate setting for hospitals, under which all payers (e.g., Medicare, Medicaid, private insurers and employer self-insured plans) pay hospitals the same price for services. Although-payer rate setting was popular in the 1970s, Maryland is the only state where it remains. Building on its all-payer rate setting approach, Maryland began implementing an all-payer global budgeting model for hospitals in 2014, while Pennsylvania began a similar model for rural hospitals in 2017. Vermont has developed an all-payer model for accountable care organizations (ACOs) that enables Medicare, Medicaid and private insurers to pay ACOs differently than through fee-for-service. These more recent all-payer payment models are still in the early stages of implementation and continue to undergo refinements and ongoing evaluation. Hospitals under this model are exempt from Medicare's inpatient and outpatient prospective payment systems and instead are paid based on fixed annual budget amounts for inpatient and outpatient hospital services that are established in advance.

A federally-funded evaluation of the first three years of Maryland's all-payer model found that it reduced total expenditures and hospital expenditures for Medicare patients but did not impact total expenditures or hospital expenditures for privately insured patients.[23] The evaluation further found that hospitals have adapted to global budgets without being adversely impacted financially. Other studies have looked at hospitals in eight urban counties in Maryland and the state's earlier rural pilot program, and research is ongoing. Accordingly, the Council believes that it may be premature to draw meaningful conclusions about the potential impact of hospital rate-setting in states with highly concentrated hospital markets.

All-payer rate setting for hospitals is intended to increase price competition and lessen the bargaining power of dominant hospitals, and it moves hospitals away from fee-for-service. However, appropriate payment rates can be challenging to establish and the model can be costly for states to administer.[24] Strong state leadership as well as an established information technology infrastructure are needed for all-payer global budgeting to be successful.[25]

Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency that monitors health care spending growth and makes policy recommendations regarding health care payment and delivery reforms. Among other responsibilities, the HPC—established in 2012—is charged with monitoring changes in the health care market. Massachusetts regulations stipulate that health care provider organizations with more than $25 million in revenue must notify the HPC before consummating transactions for the purpose of enabling the state watchdog to conduct a "cost and market impact review."[26] The HPC has conducted several such reviews of proposed hospital mergers over the years and made them available to stakeholders as well as the public, thereby increasing transparency surrounding these transactions. Notably, mergers may be allowed to move forward despite criticisms from the HPC.

AMA RESOURCES

Recognizing that physicians are increasingly becoming employed by hospitals and health systems, the AMA has developed several practical tools for physicians, including the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement which assist in the negotiation of employment contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called "Unwinding Existing Arrangements" that guides employed physicians on how to "unwind" from their organization, factoring in operational, financial, and strategic considerations.

AMA principles for physician employment (Policy H-225.950) have been codified to address some of the more complex issues related to employer-employee relationships, and the AMA Physician's Guide to Medical Staff Bylaws is a useful reference manual for drafting and amending hospital medical staff bylaws. The AMA has also developed a series of model state bills, available from the AMA's Advocacy Resource Center, that are intended to address concerns expressed by employed physicians. Through these resources, the AMA is well-positioned to help employed physicians and those considering employment by hospitals or other corporations to preserve physician autonomy and independent decision-making and protect patient-physician relationships. The inviolability of the patient-physician relationship is a recurrent theme throughout the AMA Code of Medical Ethics, which also addresses mergers of secular and religiously affiliated health care institutions

(Code of Medical Ethics Opinion11.2.6). AMA staff are available to provide guidance and consultation on a range of issues related to employment and consolidation.

Working Toward Integrated Leadership Structures

Importantly, the AMA has always supported the ability of physicians to choose their mode of practice. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems. The AMA has collaborated with hospitals, independent physician associations, large integrated health care systems' leaders and payers to cultivate successful physician leadership that improves the value of care for patients. Working with these stakeholders to bring clinical skills and business insights together at the leadership level, the AMA is fostering a more cohesive and integrative decision-making process within hospitals and health care systems. To help hospitals and health care systems institute that kind of decision-making process, the American Hospital Association (AHA) and the AMA released "Integrated Leadership for Hospitals and Health Systems: Principles for Success" in June 2015. The "Principles" provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management.

RELEVANT AMA POLICY

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Antitrust relief for physicians that enables physicians to negotiate adequate payment remains a top priority of the AMA under Policies H-380.987, D-383.989, D-383.990 and H-383.992. Under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models without being employed by a hospital or ACO. Policy D-385.962 directs the AMA to support antitrust relief for physician-led accountable care organizations. Policy H-225.950 outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations.

The AMA has substantial policy intended to protect medical staffs, including Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. Policy H-215.969 provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. Policy H-215.969 also states that the AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services. Under Policy H-235.991, medical staff bylaws should include

successor-in-interest provisions to protect medical staffs from a hospital ignoring existing bylaws and establishing new bylaws to apply post-merger, acquisition, affiliation or consolidation.

Policy H-225.947, which was established via Council on Medical Service Report 5-A-15, "Hospital Incentives for Admission, Testing and Procedures," encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models that employ physicians on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans. Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, "Principles for Physician Employment," discourages physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program. Under Policy H-140.984, the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition.

DISCUSSION

The Council shares the concerns among physicians regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the literature, the Council received input from AMA antitrust experts during the development of this report, and notes that AMA staff are readily available to assist and advise AMA members and state medical associations with questions or concerns about physician-hospital relations or hospital consolidation. Nonetheless, the AMA does not have the resources to actively oppose all future hospital mergers in highly concentrated markets, as requested by Resolution 235-A-18. Attempting to address hospital mergers in the same manner that the AMA has addressed major health insurance mergers would place an undue burden on the organization's resources and may alienate many valued AMA members who work for hospitals and hospital systems.

Having prepared two reports on hospital consolidation in a two-year time period, the Council has a clear understanding of ongoing AMA efforts to monitor and respond to health care consolidation,

including engaging with the FTC and the DOJ as well as state attorneys general and insurance commissioners. The Council further appreciates the abundance of AMA policy embracing competition and choice, and concludes that hospital consolidation is sufficiently addressed (and not prohibited) by existing policy. Accordingly, the Council developed a new policy recommendation that brings together existing AMA policy to affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

The Council also recognizes that most hospital markets are highly concentrated, and that hospital markets are predominantly local. The Council's review of the literature found that antitrust efforts may not be effective in hospital markets that are already highly concentrated, and that alternative solutions are warranted. Accordingly, the Council recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state CON laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

Because hospital markets are local, the Council further recommends encouraging state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Having discussed the potential impact of hospital consolidation on medical staffs, and the need to protect affected medical staffs post-merger, the Council recommends reaffirmation of four policies intended to help guide medical staffs and physicians experiencing consolidation: Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve critical issues; Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation; Policy H-225.950, which outlines AMA Principles for Physician Employment; and Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy.

The Council is intrigued by state efforts to promote competition, including Maryland's all-payer rate setting model and Massachusetts' HPC. The AMA will continue to monitor these and other models but, at this time, does not make recommendations regarding their widespread adoption.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 235-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. (New HOD Policy)

2. That our AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency. (New HOD Policy)

3. That our AMA encourage state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. (New HOD Policy)

4. That our AMA reaffirm Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations, and that discourage physicians from entering into agreements that restrict their right to practice medicine for a specified period of time or in a specified area upon termination of employment. (Reaffirm HOD Policy) and

7. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked: that our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs."

Although the Council agrees with the sentiment that the GPO safe harbor is flawed, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Most research studies are funded by interested parties, and a limited economic model with no funding ties to GPOs, PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same as when the safe harbor was present. Thus, repeal would not affect any party's profits or costs. In a broader economic model, a study found that total purchasing cost of the providers is not affected by the presence of the GPO administration fees, although providers may experience higher unit prices. Accordingly, the Council recommends reaffirming Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

Additionally, the Council is concerned that, if the GPO safe harbor is repealed, GPOs and PBMs could simply shift fees into other forms, such as rebates or other fees, rather than lose their revenue stream. Moreover, the Council believes that repeal of the GPO safe harbor could create widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the defects in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care. Accordingly, the Council recommends renewing efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. The Council also recommends supporting efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-19

Subject:	Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor (Resolution 252-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked:

> That our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that "Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs."

This report provides background on GPOs, how they function, and the relevant federal anti-kickback statute; details how the GPO safe harbor is used by PBMs; outlines possible antitrust and anticompetitive concerns with the GPO safe harbor; specifies the possible legal and patient access implications of repeal of the safe harbor; and offers recommendations to refine the GPO safe harbor operations.

BACKGROUND

At the 2016 Annual Meeting, Resolution 201-A-16, "Repeal of Anti-Kickback Safe Harbor for Group Purchasing Organizations," sponsored by the Medical Student Section, asked the AMA to support the repeal of the Anti-Kickback safe harbor for GPOs. Resolution 201-A-16 was referred for decision by the House of Delegates. The Council on Legislation discussed and provided input for the Management Report for Board Action, which recommended not adopting Resolution 201-A-16. The Board voted that Resolution 201-A-16 not be adopted.

At the 2018 Annual Meeting, concern was raised during the reference committee hearing regarding Resolution 252-A-18 that its proposed solution of repealing the GPO safe harbor could be both ineffective and counterproductive in addressing the identified problems of drug shortages and pricing. With respect to GPO pricing incentives, testimony also stated that GPO contracts are voluntary in nature. GPO customers may have the ability to purchase products and services off-contract if they find a preferable or better-priced option. Testimony further indicated that GPO customers include not only hospitals, but also clinics, ambulatory surgery centers, and other

provider arrangements. As such, physician-owned hospitals and other physician practice settings may be adversely impacted if the viability of the GPO business model is compromised.

HOW A GPO FUNCTIONS

GPOs are organizations that act as purchasing intermediaries that negotiate contracts between their customers—health care providers—and vendors of medical products. A GPO is generally made up of provider-members, and such members may receive profits from the GPO. A provider joins a GPO to "incur a lower purchasing cost . . . by buying through the GPO [rather] than by contracting for the same item directly with a manufacturer. GPOs assert that they are able to lower their provider-members' price per unit by employing market intelligence and product expertise that no single member could afford, and by contracting for the group's combined purchase quantity. GPOs are able to lower a provider's contracting cost by spreading its own, presumably higher, fixed contracting cost over its many members."[1] For example, AMA members can receive practice discounts through Henry Schein Medical for medical, surgical, pharmaceutical, and equipment purchases.[2] Henry Schein is partnered with GroupSource, a GPO serving the non-acute physician market, to offer physicians a wide range of products.[3]

GPOs earn revenue from several sources:

- Administrative fees paid by the manufacturer of products;
- Membership fees from provider-members;
- Administrative fees charged to distributors authorized to distribute products under a GPO's contract;
- Miscellaneous service fees that are charged directly to provider-members; and
- Other sources of revenue like outside investments.

GPOs offer a variety of services that may be paid by the administration fees or through direct charging to provider members. The U.S. Government Accountability Office identifies the funding methods that GPOs reported using for the services they provided:[4]

Table 3: The Six Largest Group Purchasing Organizations' (GPO) Reported Funding Methods for Services Provided in 2008

Service[a]	Number of GPOs offering service	Number of GPOs funding only through administrative fees	Number of GPOs funding only through charges to customers	Number of GPOs using both funding methods
Custom contracting	6	2	2	2
Clinical evaluation and standardization	6	4	0	2
Technology assessments	6	5	1	0
Supply-chain analysis	5	1	1	3
Electronic commerce	5	2	0	3
Materials management consulting	5	1	1	3
Benchmarking data	5	1	1	3
Continuing medical education	5	4	0	1
Market research	4	2	2	0
Materials management outsourcing	3	0	3	0
Patient safety services	3	2	1	0
Marketing products or services	3	2	1	0
Insurance services	2	1	1	0
Revenue management	2	0	2	0
Warehousing	1	1	0	0
Equipment repair	1	1	0	0
Other[b]	3	2	0	1

STATUTORY AND REGULATORY BACKGROUND ON THE FEDERAL ANTI-KICKBACK STATUTE

The federal anti-kickback statute provides *criminal* penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce business reimbursed under the Medicare or state health care programs.[5] The offense is classified as a felony, and is punishable by fines of up to $100,000, imprisonment for up to 10 years, and subjects the offending party to false claims act liability. The Secretary of the US Department of Health and Human Services (HHS) delegated authority over the anti-kickback statute to the HHS Office of Inspector General (OIG).

This provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs.

Because of the broad reach of the statute, concern was expressed that some relatively innocuous commercial arrangements were covered by the statute and, therefore, potentially subject to criminal prosecution. In response, Congress provides statutory exceptions from illegal remuneration where the anti-kickback statute does not apply. In addition, Congress specifically required the development and promulgation of regulations, the so-called safe harbor provisions, that would specify various payment and business practices that would not be treated as criminal offenses under the anti-kickback statute, even though they may potentially be capable of inducing referrals of business under federal health care programs.[6] In authorizing HHS to protect certain arrangements and payment practices under the anti-kickback statute, Congress intended that the safe harbor regulations be updated periodically to reflect changing business practices and technologies in the health care industry.

Accordingly, the legal framework governing the anti-kickback statute includes both statutory exceptions *and* regulatory safe harbors. The federal government considers the statutory exceptions and regulatory safe harbors as co-terminus, meaning that they cover the same conduct and the regulatory safe harbor is implementing the statutory safe harbor. Industry and the provider community have argued that they are distinct, separate protections. For example, a provider could receive protection under the statutory exception for discounts even if the arrangement would not fit within the counterpart regulatory safe harbor. Whether the protections are co-terminus or distinct is an open legal question that depends on the legal precedent of case law in each federal circuit (if a circuit has considered this specific issue).

This report will focus on three specific statutory exceptions and regulatory safe harbors that may cover the various funding mechanisms of GPOs: (1) GPO safe harbor; (2) discount safe harbor; and (3) personal services and management contracts safe harbor.

GPO Statutory Exception and Regulatory Safe Harbor

With GPOs, Congress enacted section 9321 of the Omnibus Budget Reconciliation Act of 1986, which excludes from the definition of "remuneration" certain fees paid by vendors to GPOs from prosecution under the anti-kickback statute.[7] According to the legislative history, Congress believed that GPOs could "help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged."[8]

In 1991, OIG issued a final rule implementing a GPO safe harbor to apply to payments from vendors to entities authorized to act as a GPO for individuals or entities who are furnishing Medicare or Medicaid services. The proposed safe harbor required a written agreement between the GPO and the individual or entity that specifies the amounts vendors will pay the GPO.

To qualify for protection under the GPO safe harbor, a GPO must have a written agreement with each individual or entity for which items or services are furnished. That agreement must either provide that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of three percent or less of the purchase price of the goods or services provided by that vendor or, in the event the fee paid to the GPO is not fixed at three percent or less of the purchase price of the goods or services, specify the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

Where the entity that receives the goods or services from the vendor is a health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity. As explained in the preamble to the final regulations, the safe harbor is not intended to protect fees to arrange for referrals or recommendations within a single entity.[9] Therefore, the safe harbor provides that "Group Purchasing Organization" means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs, and who are neither wholly owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly owned entity).

Thus, if a GPO meets the above requirements, it fits within the GPO safe harbor and its administrative fees will not be subject to criminal prosecution under the anti-kickback statute. Of course, these administrative fees may cover a variety of services.

Discount Statutory Exception and Regulatory Safe Harbor

The discount statutory exception applies to arrangements where there is a discount or other reduction in price that was obtained by a provider or other entity when such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed.[10] Congress included the discount exception to "ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal."[11]

The regulatory discount safe harbor exempts from the definition of remuneration discounts on items or services for which the federal government may pay and certain disclosure requirements are met.[12] A discount means a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction. In addition, rebates are also covered under the discount safe harbor to mean an amount that is described in writing at the time of the purchase but is not paid at the time of sale. The safe harbor also specifically excludes from the definition of a discount cash or cash-equivalents (except for rebates in the form of a check); certain swapping arrangements (e.g., induce purchasing one good for another good); exempted remuneration from other safe harbors (e.g., warranties); and other remuneration, in cash or in kind not explicitly described by the safe harbor.

The regulatory safe harbor disclosure requirements vary based on the type of entity—buyer, seller, offeror—in the discount arrangement. Moreover, a buyer's disclosure requirements depend on

whether the entity is (1) acting under a risk contract; (2) reports costs on a cost report; or (3) submits a claim or a request for payment is submitted for the discounted item or service and payment may be made, in whole or in part, under Medicare, Medicaid, or other federal health care programs.[13]

Thus, a GPO's up-front discount is covered by the statutory exception and the regulatory safe harbor if properly disclosed, and it will not be subject to criminal prosecution under the anti-kickback statute.

Personal Services and Management Contracts Regulatory Safe Harbor

This safe harbor protects certain payments made by a principal to an agent as compensation for the agents' services. Protection applies only if certain standards are met that "limit the opportunity to provide financial incentives in exchange for referrals."[14] These standards include that aggregate compensation is set in advance, consistent with fair market value in an arms-length transaction, and not determined in a manner that takes into account the volume or value of any referrals or business generated between the parties.[15]

Thus, if a GPO offers additional services that go beyond the administration fees (i.e., direct charges to the provider-members), the GPO may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the anti-kickback statute.

APPLICATION TO PHARMACY BENEFIT MANAGERS

Overall, the application of the anti-kickback safe harbors and exceptions to PBMs is difficult because PBMs and their current activities were not prevalent or existent when the safe harbors were created.

GPO Statutory Exception and Regulatory Safe Harbor

The OIG's only formal pronouncement on PBMs and the GPO regulatory Safe Harbor is found in sub-regulatory guidance: Compliance Program Guidance for Pharmaceutical Manufacturers issued in 2003.[16] "Any rebates or other payments by drug manufacturers to PBMs that are based on the PBM's customers' purchases potentially implicate the anti-kickback statute." Protection is available by structuring such arrangements to fit in the GPO safe harbor. That safe harbor requires, among other things, that the payments be authorized in advance by the PBM's customer and that all amounts actually paid to the PBM on account of the customer's purchases be disclosed in writing at least annually to the customer and to HHS upon request. In addition, Medicare Part D sponsors and other entities that provide PBM services are required to report various data elements to CMS. The statute specifies that this data is confidential and generally must not be disclosed by the government or by a plan receiving the information.[17]

The OIG potentially extended the GPO regulatory Safe Harbor, which is meant to cover administrative fees, to include "any rebates or other payments." Thus, PBMs can argue that fees and rebates have protection under the GPO Safe Harbor. However, PBMs would attempt to fit non-administrative fees within different safe harbors first and then potentially rely on GPO Safe Harbor as a backstop.[18]

Discount Statutory Exception and Regulatory Safe Harbor

On February 6, 2019, HHS issued a proposed rule to amend the safe harbor regulations concerning discounts.[19] HHS is proposing to disallow these traditional discount/rebate arrangements for plan sponsors under Part D and Medicaid Managed Care Organizations and attempt to instead pass any price concession directly to the beneficiary at the point-of-sale of the drug. To do this, they are proposing changes to the anti-kickback safe harbor regulation concerning discounts. Under the proposal, CMS would eliminate the current safe harbor protections for discounts paid by manufacturers directly to plan sponsors and PBMs. HHS also proposes the creation of two new safe harbor protections: protection for reductions in price at the point-of-sale and protection for fixed fees paid to PBMs for services rendered to manufacturers.[20]

In its formal response to the proposed rule, the AMA commented that OIG either needs to eliminate the application of the GPO regulatory safe harbor to PBMs or clarify its application only to administrative fees and define what services are covered. The AMA's comments went on to state that PBMs may be able to avail themselves to existing regulatory safe harbors including the GPO safe harbor, the personal services and management contracts safe harbor, managed care safe harbor, and the proposed certain PBM services safe harbor. The AMA requested that the Department clarify what PBM fees and services apply to both the proposed and existing safe harbors. Otherwise, the AMA is concerned that the lack of clarity may provide further opportunity for exploitation.

Moreover, on May 16, 2018, Secretary Azar noted: "We would welcome the PBM industry coming forth with broader proposals for moving away from today's system, including a plan for implementation with the pharmaceutical industry. But we also have the administrative power to end this system ourselves—to eliminate rebates and forbid remuneration from pharmaceutical companies, align interests, and end the corrupt bargain that keeps driving list prices skyward." In his comments before the Senate Health, Education, Labor & Pensions Committee, Secretary Azar went further, noting: "Rebates are allowed under an exception to the Anti-Kickback Statute, and that's an exception that we believe by regulation we could modify."

In the legal community, there is debate as to whether a PBM truly meets the definition of a "buyer" under the regulatory discount safe harbor considering PBMs do not take physical possession of the drugs. That said, most discount arrangements between PBMs and drug manufacturers (or other entities) are structured to fit within the discount safe harbor.

Personal Services and Management Contracts Regulatory Safe Harbor

As with GPOs, if a PBM offers additional services that go beyond the administration fees (e.g., data analytics, disease management), the PBM may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the anti-kickback statute.

Summary Table

	GPO	**PBM**	**Anti-Kickback Statute exception/safe harbor**
Administrative Fees	~3%	~4.5-5%[21]	Protected by the GPO safe harbor
Type of Discount	Up front discount at time of purchase	After the purchase rebate	Protected by the Discount safe harbor
Other fees	Data analytics, market research, clinical evaluation, etc.	Data analytics, disease management	If applicable, protected by the Personal Services safe harbor

ANTITRUST AND COMPETITION CONCERNS

In response to antitrust concerns in the health care area, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) from 1993-1996 issued policy statements involving mergers and various joint activities in the health care arena.[22] Statement 7 discusses DOJ/FTC enforcement policy involving health care providers' joint purchasing agreements, which includes GPOs. Generally, DOJ/FTC believe that most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns because the participants frequently can obtain volume discounts, reduce transaction costs, and have access to other services like consulting advice that may not be available to each participant on their own. Absent extraordinary circumstances, the agencies will not challenge any joint purchasing arrangement if it is in the "Antitrust Safety Zone."

Two conditions must be present to enter the zone:

(1) The purchases by the health care provider account for less than 35 percent of the total sales of the purchased product or services in the relevant market.
(2) The cost of the products and services purchased jointly accounts for less than 20 percent of the total revenue from all products or services sold by each competing participant in the joint purchasing arrangements.

The agencies also listed certain safeguards that joint purchasing arrangements can adopt to minimize concerns including not requiring the use of arrangements for all services; having an independent employee or agent negotiate on behalf of the joint purchasing arrangement, and ensuring communications between the purchasing group and participants are kept confidential.

Since this guidance was issued, GPO market consolidation has increased and led to an oligopoly market structure for national GPOs. The five largest GPOs by purchasing volume have approximately 85-90 percent of the market[23] and in 2017 the top four GPOs reported a total purchasing volume of $189 billion.[24]

Competition concerns are also raised when it comes to contracts between GPOs and vendors including sole-source contracting, minimum purchasing requirements that may cause overspending, length of the contract (5+ years in some instances), and bundling.

- Sole-source contracts: In a GAO report, all five major GPOs reported that they do negotiate sole-source contracts when it is advantageous to their customers, though some GPOs reported negotiating a higher proportion of sole source contracts than others. One GPO said that about 18 percent of its customers' spending through the GPO is through sole-source contracts. Three GPOs reported sole-source contracting for branded drugs and

commodities, and four GPOs reported sole-source contracting for generic drugs, including generic injectable drugs.

- Contracts that bundle related products: GPOs report negotiating contracts that offer discounts based on the purchase of bundled products, but restricting bundling to products that are used together or are otherwise related in order to create efficiencies and help standardize products for their customers.
- Long-term contracts: GPOs report awarding longer terms for certain types of products, such as IV systems and laboratory products.

Alternatively, all GPO contracts are voluntary and the product of market negotiations. Hospitals and other health care providers are generally not required to only contract with one GPO and may belong to multiple GPOs. Vendors are not required to contract with GPOs and health care providers are not required to use the contracts negotiated by GPOs with their vendors. While GPOs may negotiate sole-source contracts, providers are generally not required to purchase through their GPO contracts but can instead purchase supplies "off contract" by negotiating their own prices directly with suppliers.[25] In economic models, on-contract prices are not necessarily the lowest available. In fact, off-contract prices are sometimes lower. However, off-contract prices could be lower than on-contract prices because of the presence of the GPO. Without the GPO, the off-contract price could potentially be higher.[26]

In addition to the above concerns related to GPO contracts, PBM contracting mechanism may also have an impact on competition. Complaints about the PBM contracting process include employers wanting an alternative to a rebate-driven approach to managing costs, PBMs lacking transparency about how they generate revenue, contracts being complicated and including clauses that benefit the PBM at the expense of the employer or patient, and rebates contributing to misaligned incentives that put PBM interests before patients or employers (no fiduciary obligation).[27]

Contributing Factors to Drug Shortages

Drug shortages remain an ongoing public health concern in the United States. Although the rate of new shortages has decreased, long-term active and ongoing shortages have not been resolved and critical shortages continue to impact patient care and pharmacy operations. Several commonly used products required for patient care are in shortage including sterile infusion solutions (e.g., saline, amino acids, dextrose), as well as diazepam, lidocaine, hydromorphone, and morphine.

Proponents supporting the repeal of the GPO Safe Harbor state the root cause of drug shortages is the existence of the GPO Safe Harbor.[28] However, the drug shortage issue is multi-factorial and complex. Ongoing supply challenges of certain medications, typically injectable products that are off-patent and have few suppliers, persist. Causes of these shortages continue to remain largely unchanged:

- Quality problems – drug shortages are mostly triggered by quality problems during manufacturing processes which causes manufacturers to slow or halt production to address these problems.
- Limited inventory – widespread use of just-in-time inventory practices can increase the vulnerability of the supply chain to shortages.
- Regulatory approval – new manufacturers may not be able to quickly enter the market to produce a drug in shortage because the U.S. Food & Drug Administration's (FDA) approval is required. Existing manufacturers also need FDA approval of changes to manufacturing conditions or processes.

- Production complexity – costly, specialized equipment is required to manufacture drugs and maintaining sterility throughout the production process is challenging and may require facilities dedicated solely to those drugs.
- Constrained manufacturing capacity – in the generic sterile injectable market, the industry is concentrated and has limited manufacturing capacity. The pressures to produce many drugs on only a few manufacturing lines can leave manufacturers with little flexibility when one manufacturer ceases production of a particular drug.

With respect to GPOs, a 2014 GAO report in examining causes of drug shortages was inconclusive and, importantly, did not mention the GPO safe harbor as a causal factor of drug shortages.[29] Accordingly, while the presence of the GPO safe harbor may be a factor in drug shortages, drug shortages are multi-factorial, no consensus exists as to what percentage, if any, the safe harbor contributes to drug shortages, and no empirical evidence exists that the safe harbor is the root cause of drug shortages.

Contributing Factors to Drug Pricing

Proponents supporting the repeal of the GPO Safe Harbor also state that the safe harbor causes unprecedented drug price spikes.[30] While impacted by supply chain dynamics, other contributing factors to pharmaceutical pricing include the type of pharmaceutical (generic, brand, biologic), level of negotiation authority of the purchasing entity, and market exclusivity and manipulations. At the front-end, pharmaceutical manufacturers set a drug's list price, which does not include discounts or rebates. The list price is set to cover costs of production, research and development, and profits. Patients who are uninsured and in high-deductible health plans have greater exposure to the list price; for other patients who are insured, it more represents a starting price in the distribution chain from wholesalers to pharmacies to patients, ultimately impacting patient cost-sharing levels. While concerns have been raised that the rebate process between pharmaceutical companies and PBMs results in list prices above what they would be absent rebates, other key factors foundationally impact a drug's list price.

When addressing the pricing of brand-name drugs, such factors include the number of individuals expected to use the drug, development costs, and competition in the marketplace. Brand-name drugs have 20 years of patent protection from the date of filing, and also enjoy a period of market exclusivity, depending on the type of drug. Orphan drugs – drugs to treat rare diseases or conditions affecting less than 200,000 individuals in the U.S., or affecting more than 200,000 individuals but for which there is not a reasonable expectation that the sales of the drug would recover the costs – have seven years of market exclusivity. Drugs deemed to be innovative products that include an entirely new active ingredient – a new chemical – have five years of market exclusivity. Six months of exclusivity are added to existing exclusivity periods once studies on the effects of a drug upon children are submitted for FDA review and meet the statutory requirements.[31]

Currently, biologic manufacturers have 12 years of market exclusivity for innovator products. Innovator biologics also have additional patent protection that generally exceeds the market exclusivity period by a few years. Overall prices for biologics are higher resulting from the high risk and expense of manufacturing these products, the special handling and administration required, and an overall lack of competition in the marketplace. Biosimilars can offer some cost savings in comparison with their originator equivalents, but thus far not at the level seen between traditional brand-name and generic drugs.

Brand-name drug manufacturers have also used various techniques to delay competition in the marketplace or lengthen patent protection. In reverse-payment patent litigation settlements, also known as "pay-for-delay" settlements, a brand-name drug manufacturer pays a potential generic competitor to abandon its patent challenge and delay offering a generic drug product for a number of years. Brand-name manufacturers can also attempt to effectively extend the term of patent protection for a single product by creating a patent portfolio, composed of patents with staggered terms for modified forms of the same drug, new delivery systems for that drug, or other variations of the original product, a practice known as "evergreening." Examples of evergreening include reformulating a drug as extended release or changing the mix of chemical isomers. In situations where a newer version of an existing brand-name drug enters the marketplace, brand-name manufacturers can also choose to take the older drug off the market or restrict access to the older drug, including by limiting its distribution through select specialty pharmacies.

Several factors can impact the prices of generic drugs, including drug shortages, supply disruptions, limits in manufacturing capacity, and generic drug industry mergers and acquisitions. In addition, generic drug companies may transition to manufacture drugs recently off patent to gain early market share, while others have chosen to manufacture generic drugs that have been on the market for some time and no longer have ample competition.

Patient out-of-pocket costs for the same prescription drug can vary based on the health plan in which they are enrolled. Certain government programs, including Medicaid, the Veterans Affairs and Department of Defense, secure discounts and/or rebates on the price of prescription drugs. In most other coverage situations, patient cost-sharing levels result from insurer/PBM-pharmaceutical company negotiations, and depend on whether drugs are on their health plan formulary, and if so, at what cost-sharing tier.

Our AMA policies on drug shortages and pricing advocate pursing a collaborative approach focused on finding the root causes of problems. Blaming GPOs for the complicated drug shortage problem risks compromising this solution-oriented strategy, especially without a current policy consensus on this point. With respect to GPO pricing incentives, it is important to keep in mind that GPO contracts are voluntary in nature. GPO customers retain the ability to purchase products and services off-contract if they find a preferable or better-priced option.

DISCUSSION

Throughout the evolution of this report, the Council on Medical Service welcomed input from the Council on Legislation and thanks the Council on Legislation for its thoughtful comments throughout the drafting process. The Council on Medical Service is confident that the collaboration between the Councils was essential to the formulation of a measured report on a highly complex subject and the nuances therein.

The GAO has expressly declined to call for eliminating the safe harbor as the appropriate solution, noting that "a repeal of the safe harbor provision would require a clearer understanding of the impact of the GPO funding structure." GAO emphasized, and the Council agrees, that eliminating the safe harbor could have unintended consequences, at least in the short term:

> Some experts believe there is an incentive for GPOs to negotiate higher prices for products and services because GPO compensation increases as prices increase. However, other experts, as well as GPOs, stated that there is sufficient competition between them to mitigate any potential conflicts of interest. Almost 30 years after its passage, there is little empirical evidence to definitively assess the impact of the vendor-

fee-based funding structure protected under the safe harbor. While repealing the safe harbor could eliminate misaligned incentives, most agree there would be a disruption while hospitals and vendors transitioned to new arrangements. Over the longer term, if the current trend of hospital consolidation continues, the concerns about these disruptions may be diminished to the extent that large hospital systems may be in a better position to pay GPOs directly for their services or negotiate contracts with vendors on their own. Furthermore, given that some hospitals are already paying a subsidiary of one GPO directly for access to vendor contracts, alternative approaches are possible.[32]

GPO Studies

As mentioned by the GAO, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Most research studies are funded by interested parties like the Healthcare Supply Chain Association. A limited economic model with no funding ties to GPOs, PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same as when the safe harbor was present. Thus, repeal would not affect any party's profits or costs.[33] In a broader economic model, a study found that total purchasing cost of the providers is not affected by the presence of the GPO administration fees, although providers may experience higher unit prices.[34]

Legal Impact of Fitting GPOs or PBMs Within Personal Services Safe Harbor

If the GPO safe harbor were repealed, the Council believes that GPOs and PBMs simply could shift fees into other forms, such as rebates or other fees, rather than lose their revenue stream. For example, the current administrative fee could fit within the personal services and management contracts safe harbor or fit within enough factors of the safe harbor that OIG would use its enforcement discretion and not pursue criminal charges against the GPO or PBM.[35] This safe harbor covers a wide variety of conduct. The Council notes that the personal services category covers many types of services provided in the health care industry including professional physician services provided under an independent contractor arrangement, a physician group providing medical services to a hospital, and medical director agreements. The management contracts category covers all non-professional services billing and collection, accounting, marketing, purchasing, staffing, recruiting, quality assurance, and facilities and personnel management.

In this case, the GPO Safe Harbor three percent or 4.5 - 5 percent administration fee could be repackaged under the personal services and management contracts safe harbor as a management contract. To fit within that safe harbor, a GPO or PBM would need to meet the following requirements:

1. Agreement in writing and signed;
2. Covers all of the services provided;
3. Not less than one year;
4. Aggregate compensation paid to the agent (GPO) over the term of the agreement is set in advance, is fair market value, and does not take into the volume or value of any referrals of federal health care program beneficiaries;
5. Arrangement does not violate any state or federal law;
6. Contracted services do not exceed what is reasonably necessary to accomplish the commercially reasonable business objective; and
7. If services are on a part-time basis (e.g., part-time housekeeping), lay out schedule of internals, precise length, and exact charge for such intervals.

Repackaging the administrative fee into the personal services and management contracts safe harbor may not squarely meet all of the safe harbor's requirements because a percentage may not be an aggregate compensation set in advance. OIG is silent on fixed percentages laid out in advance under this exception. OIG, in Advisory Opinions, does allow performance or other percent bonuses as compensation even if it does not fit squarely within the safe harbor. In those instances, OIG uses its enforcement discretion to decline to pursue (e.g., lack of intent). There is also a low risk that the compensation (three percent) was payment for patient referrals because the percentage does not directly vary with the number of patients treated. With determining fair market value, OIG would likely find the three percent GPO fee or the 4.5 percent PBM fee to be fair market value given the percentage of the market that uses these percentages in practice.

Moreover, specifically regarding PBMs, the Council notes that CMS Report 5-A-19, which is before the House of Delegates at this meeting, recommends supporting the active regulation of PBMs under state departments of insurance, supporting efforts to ensure that PBMs are subject to federal laws that prevent discrimination against patients, and supporting improved transparency in PBM operations including a list of disclosures.

Impact on Patient Care

The Council strongly believes that repeal of the GPO safe harbor may also have, at least in the short-term, widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the flaws in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care.

Accordingly, the Council believes that adopting a policy to oppose the GPO safe harbor may not only hurt the AMA's credibility but also will not accomplish the objectives set forth by proponents of repeal because limited economic studies show no impact on repeal, entities involve may continue to operate the same practices under a different safe harbor, and repeal would potentially cause a disruption of care and the supply chain.

Instead, the Council believes that the AMA should promote greater transparency and accountability efforts regarding the actions covered by the GPO and PBM anti-kickback safe harbor. In 2014, GAO recommended that CMS should determine whether hospitals are appropriately reporting administrative fee revenues on their Medicare cost reports and take steps to address any underreporting that may be found. In response, CMS issued a Technical Direction Letter to the Medicare Administrative Contractors (MACs) in 2015 adding steps to the desk review program. Specifically, CMS directed MACs to verify that GPO revenues have been offset where appropriate in order to mitigate any risk to the Medicare program. However, nothing has been publicly released based off of these desk reviews. Moreover, HHS has the capability to request records from GPOs the amount received from each vendor with respect to purchases made by or on behalf of the GPOs customers. Yet, the Council is unaware of any requests or public reports based off any requests since the GAO report. Given the push for greater price and cost transparency and the lack of recent data related to GPOs and PBMs, the Council recommends that the federal government renew efforts to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor.

Additionally, the Council believes that the AMA should focus efforts on modernizing the fraud and abuse laws to address the changing realities of the health care delivery and payment system. The

Anti-Kickback Statute was passed in 1972, Stark (physician self-referral law) in 1989. Significant changes in health care payment and delivery have occurred since the enactment of these laws. For example, PBMs did not exist, or were at least not as pervasive, when these laws were created. Numerous initiatives are attempting to align payment and coordinate care to improve the quality and value of care delivered. The delivery of care is going through a digital transformation with innovative technology. However, the fraud and abuse laws have not commensurably changed.

The fraud and abuse laws were enacted during a time when fee-for-service, which pays for services on a piecemeal basis, was blamed for rising costs. The policy reasoning behind the fraud and abuse laws is to act as a deterrent against overutilization, inappropriate patient steering, and compromised medical judgment with heavy civil and criminal penalties, such as treble damages, exclusion from participation in federal health care programs, and potential jail time.

The health care system has evolved since the creation of these laws, and the Council believes that they need to be updated to reflect changing business practices and technologies in the health care industry.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 252-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-125.986 supporting efforts to ensure that reimbursement policies established by pharmaceutical benefit managers (PBMs) are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.992 stating that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs (Reaffirm HOD Policy)

4. That our AMA renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. (New HOD Policy)

5. That our AMA support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages. (New HOD Policy)

Fiscal Note: Less than $500

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[12] 42 CFR § 1001.952(h).
[13] Medicare rules generally require providers to offset purchase discounts, allowances, and refunds against expenses on their Medicare cost reports. In 2005, OIG reviewed 21 GPO members, and found that they did not fully account for net revenue distributions on their Medicare cost reports. There was considerable variation among the GPOs, with members of one GPO offsetting 92 percent of the distributions, members of another offsetting only 54 percent. In total, 22 percent of net revenue distributions were not offset. OIG, Health Care Fraud and Abuse Control Program Annual Report for FY 2005, (Aug. 2006), https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.pdf.
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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-19

Subject: Health Plan Payment of Patient Cost-Sharing (Resolution 707-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 707, which was introduced by the California Delegation and assigned to the Council on Medical Service for study. Resolution 707-A-18 asked:

> That our American Medical Association (AMA) urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles.

This report provides an overview of patient cost-sharing obligations including the rise of high-deductible health plans, highlights patient collection management practices by insurers, summarizes relevant AMA policy, provides a summary of relevant AMA advocacy activities, and recommends policy.

BACKGROUND

Despite coverage gains in recent years, the health care system continues to struggle with decreasing the number of uninsured patients and, even for the insured population, utilizing health care services is often unaffordable. For the insured, the trend of rising health insurance deductibles has been altering health insurance from more comprehensive coverage to insurance with higher out-of-pocket costs.[1] Deductibles have gradually risen for decades and contribute to the changing nature of health insurance. One rationale behind high deductible health plans (HDHPs) is that they moderate the cost of health care and health insurance by shifting the rising cost of health care from insurers and employers to patients. Health plans with higher levels of cost-sharing generally have lower premiums and put a financial obligation of higher out-of-pocket costs on patients when services are used.[2]

The prevalence of HDHPs is not limited to the Affordable Care Act (ACA) Exchanges but also widespread in employer-sponsored coverage. Notably, the growth in HDHP enrollment has been fastest among those with employer-based coverage. About 40 percent of companies that offer health insurance make HDHPs the only choice for their employees.[3] About half of people with employer coverage have a deductible of at least $1,000.[4] Moreover, the shift to plans with rising deductibles began before the ACA was passed.[5] The average general annual deductible for employees has increased 49 percent over the last five years.[6] Overall, in 2018, 29 percent of workers with employer-based coverage were enrolled in a HDHP. Although the Council believes that health insurance should balance patient responsibility and patient choice; increasingly employees do not have a choice of coverage options.[7]

The impact of cost-sharing imposed by HDHPs is an ongoing concern for patients and physicians. HDHPs with tax-preferred savings accounts may not be a good fit for some patients, particularly low-income patients who may struggle to fund their health savings accounts (HSAs).[8] For example, there is evidence that exposing patients to increased cost-sharing has unintended and negative consequences. Overall, HDHPs can be a good option for people who are in relatively good health, but they may expose people who have more modest incomes to out-of-pocket costs that can be a barrier to care and a risk to their financial security. HDHPs also make beneficiaries increasingly vulnerable to sharp increases in drug prices. Cost-sharing, even when tied with available information on the price of services, generally does not induce patients to shop for lower-priced services. Instead, patients more often reduce their use of health services, potentially delaying needed care and exacerbating health issues. The burden of higher cost-sharing has a disproportionate impact on patients with lower incomes whose deductible may exceed available liquid assets.

The shift in financial responsibility toward patients may contribute to physicians' concerns about collecting cost-sharing from patients. However, if physicians do not collect these cost-sharing amounts, they sustain bad debt that adversely affects the financial sustainability of their practices.[9]

Bad debt typically is the difference between what providers billed patients and the amount those patients ultimately paid, and the phenomenon of bad debt has become an industry-wide issue for health care practitioners. Patient payments are an increasing share of expected revenues.[10] According to the American Hospital Association, this uncompensated care reached $38.3 billion in 2016. Bad debt may affect the financial viability of practices, and collecting on bad debt takes practice time and resources, and the additional time physician offices spend on collection of bad debt is not reflected in the cost of providing care. Moreover, the significant time used to collect on such debt may cause disruptions to the patient-physician relationship.

EXAMPLE OF INSURER PROGRAM COLLECTING COST-SHARING

To mitigate bad debt, major national health plans, including UnitedHealthcare and Anthem, have patient payment programs through InstaMed, which allow insurers to manage patient collections for the physician practice; however, there are caveats to this model. First, practices do not have a choice of if they want to receive patient payments in this manner. Therefore, if a patient signs up for InstaMed, the practice will get paid through InstaMed. Moreover, these programs typically only issue electronic payments to the practice. If the practice does not sign up for the program and receive standard electronic fund transfers, the practice will be issued a virtual credit card for the patient's payment. Importantly, such credit cards are associated with fees that tend to be 2-5 percent of the overall payment. Furthermore, practices may have reasons for wishing to manage patient payments themselves. For instance, the practice may have worked out a payment plan with the patient or there may be secondary or tertiary payers. The solution sought by Resolution 707-A-18 may negatively impact such business autonomy by precluding such arrangements. Advocating for patient payment programs may appear as an endorsement of such programs, which may be problematic for physicians and provider representatives of plans impacted by these patient collection methods. Accordingly, such action may adversely affect physician payment levels and processes, and could have unintended consequences within some physician practices.

AMA POLICY

Long-standing AMA policy and advocacy efforts acknowledge and support the business freedom of physician practices (Policies H-165.985 and H-165.838). Some physicians prefer the flexibility afforded to payment operations and do not want to cede patient collections to health plans.

Physicians currently have the ability to offer discounts or payment plans to patients to facilitate goodwill, which is an arrangement supported by long-standing Policy H-165.849. Moreover, Policy H-165.849 states that our AMA will engage in a dialogue with health plan representatives (e.g., America's Health Insurance Plans and Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in HDHPs.

Policy D-190.974 demonstrates the AMA's commitment to administrative simplification. Among numerous actions, it directs the AMA to continue its strong leadership role in automating, standardizing, and simplifying all administrative revenue cycle transactions between physicians in all specialties and modes of practice and all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses. Moreover, it directs the AMA to prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.

The AMA remains committed to health insurance affordability. Policy H-165.828 specifically encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Moreover, Policy H-165.828 supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

AMA ACTIVITY

The AMA has developed a comprehensive point-of-care pricing toolkit to help practices with patient collections (https://www.ama-assn.org/practice-management/claims-processing/managing-patient-payments). The toolkit recognizes concerns about uncollected patient financial responsibility that can result in physician practices taking on debt and contains varied resources to help mitigate the problem. This toolkit addresses point-of-care and post-visit collections and includes:

- Step-by-step guidance toward providing point-of-care pricing and collecting from patients at the time of service;
- Guidance on calculating the price of treatment at the point-of-care;
- Sample scripts to help practices collect patient payment;
- Letter templates to ask health insurers and other payers about terms and conditions of insurance contracts regarding physicians' rights to provide point-of-care pricing and collect payments at the time of care;
- Webinars designed for practices to help patients understand their financial responsibility;
- Resource providing information on how practices can implement an effective strategy for collection of payment after a patient has left the office; and
- Guidance on the steps to take when a patient fails to pay for treatment in full.

In addition to the AMA's point-of-care pricing toolkit, the AMA has repeatedly voiced its concern about virtual credit card payments and the fact that it may cause physicians to lose a significant amount of contractual payments to high interchange fees charged by the credit card companies. The AMA continuously advocates for transparency in virtual credit card payments including advanced disclosure of transaction fees and any rebates or incentives awarded to payers for using this payment method.

Furthermore, pursuant to Policy H-165.849, the AMA continues to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. The AMA continues to hold such meetings with insurers to address this issue as well as other issues relating to physician burden and practice sustainability.

DISCUSSION

Bad debt can affect the financial viability of practices, and collecting on this debt takes practice time and expense. Nonetheless, the Council is concerned about the unintended consequences of adopting Resolution 707-A-18. In particular, if insurance companies collect patient co-payments and deductibles, they would likely charge administrative fees to practices or lower physician payment levels. Nonetheless, the Council believes that the issues raised by Resolution 707-A-18 are compelling and warrant action, particularly for small physician practices that may be most impacted by an increase in bad debt brought about by some patients not fulfilling their cost-sharing obligations.

First, the Council recommends reaffirming long-standing policy illustrating the AMA's commitment to the business freedom of physician practices (Policies H-165.985 and H-165.838). Additionally, because the evidence suggests that it is not the HDHP itself that is necessarily problematic but rather the inability to meaningfully fund a corresponding HSA, the Council recommends reaffirming Policy H-165.828 encouraging the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Due to the trend of increasing use of HDHPs, the Council also recommends encouraging states and other stakeholders to monitor the growth of HDHPs and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability.

The Council believes that a factor contributing to uncompensated care is the lack of patient education on their health plans. Importantly, Policy H-165.828 also supports education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. Although the Council remains steadfast in its belief that patient education will help solve the problem of uncompensated care, it notes that the Emergency Medicine Treatment and Labor Act forbids emergency care providers from discussing with the patient any potential costs of care or details of their insurance coverage until the patient is screened and stabilized. The Council agrees with and respects this prohibition. Therefore, while the Council strongly supports patient education of costs not only at the time of enrollment but also at the time of care, the Council recognizes that this discussion is precluded at the point-of-care in the case of emergencies.

To further patient education efforts, the Council recommends amending Policy D-190.974 by updating part four by addition such that our AMA will prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in HDHPs. Following from this, the Council also believes that more sophisticated IT systems are critical to help enable physicians and empower patients to better understand financial obligations. Additionally, the Council recommends taking this opportunity to amend part six of Policy D-190.974 to reflect the ending of the Heal the Claims campaign and

instead recommends calling attention to the AMA's continued efforts to ensure that physicians are aware of automating their claims cycle.

As previously noted, the prevalence of HDHPs is not isolated to the ACA Exchanges, but is also widespread in employer-sponsored coverage. The Council believes that health insurance should balance patient responsibility and patient choice; however, increasingly patients do not have a choice of coverage options. Therefore, the Council recommends reaffirming Policy H-165.849 urging the AMA to continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasingly difficulty of practices in collecting co-payments and deductibles and the underlying issue of affordability.

The Council firmly believes that there are no easy solutions to the problem of patient collections and remains unconvinced that giving insurers additional control over the process is the best solution. Instead, the Council believes that the AMA should remain committed to addressing the concerns of its members and seeking solutions to the major issue underlying Resolution 707-A-18, which is greater affordability of health insurance premiums and cost-sharing responsibilities. Accordingly, the Council suggests a set of recommendations intended to address the root of the problem.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 707-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policies H-165.985 and H-165.838 illustrating the AMA's commitment to the business freedom of physician practices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.849 stating that the AMA will continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.828 encouraging the development of demonstration projects to allow individuals who forego cost-sharing subsidies by enrolling in a bronze plan to have access to a partially-funded health savings account and supporting additional education regarding deductibles and cost-sharing at the time of health plan enrollment. (Reaffirm HOD Policy)

4. That our AMA amend Policy D-190.974 by addition and deletion as follows:

   Administrative Simplification in the Physician Practice
   1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
   2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
   3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice

with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts ~~expand its Heal the Claims process(TM) campaign as necessary~~ to ensure that physicians are aware of the value of automating their claims cycle. (Modify Current HOD Policy)

5. That our AMA support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations. (New HOD Policy)

6. That our AMA encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. (New HOD Policy)

Fiscal Note: Less than $500

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REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Alternative Payment Models and Vulnerable Populations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked: That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Heath care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. And because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, as Resolution 712 points out, value-based payment programs can disproportionately penalize physicians serving the poorest and most vulnerable populations. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council recommends reaffirming existing AMA policies to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients, and the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10-A-19

Subject: Alternative Payment Models and Vulnerable Populations (Resolution 712-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G (Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked:

> That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

This report provides an overview of vulnerable populations and the emergence of APMs, highlights numerous APMs and value-based care initiatives incorporating social determinants of health into their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities, and recommends policy to encourage the development of APMs that serve vulnerable populations while protecting physicians from being financially penalized.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula and created new ways for the Medicare program to pay physicians for the care they provide to Medicare beneficiaries. Specifically, MACRA's physician payment program is the Quality Payment Program (QPP). The QPP has two tracks of participation: APMs and the Merit-based Incentive Payment System (MIPS). As part of the QPP's drive to value-based care, it creates incentives for physicians to participate in APMs, which aim to provide greater flexibility to manage the health of patient populations by aligning provider incentives with cost and quality goals. MACRA specifically encourages the development of Physician-Focused Payment Models (PFPMs), which are APMs wherein Medicare is the payer, physician group practices or individual physicians are APM participants, and the focus is on the quality and cost of physician services. MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess PFPM proposals submitted by stakeholders to the committee based on certain criteria defined in regulations. The PTAC is an 11-member independent federal advisory committee. Since its inception, the PTAC has received 31 proposals for consideration, a few of which have not been reviewed yet by PTAC. Of those proposals, PTAC has recommended 15 proposals to the Secretary of Health and Human Services (HHS) to test in various ways.

As the national push toward value-based payment and care delivery continues, many studies have demonstrated substantial evidence linking social circumstances to health and health outcomes.[1] It is now understood that non-medical factors, such as social determinants of health (SDH), account for about 60 percent of a person's health outcomes.[2] Together, the drive toward value and recognition of SDH impacts on health are fueling interest in the ways in which addressing SDH may be incorporated into new payment and delivery models like APMs. Within an APM, physicians often are financially rewarded for keeping patients healthy and out of the hospital and emergency departments. To achieve this goal, APMs often have the flexibility to support services that can significantly improve health outcomes. Therefore, physicians can respond to APM incentives by improving care coordination and integration, which may be particularly beneficial for vulnerable populations.

However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable patients who are at increased risk for high costs and poor outcomes that are beyond the physician's control.[3] In order to increase health equity and to fully realize the benefits of APMs, APMs must contemplate and account for vulnerable populations.

Impact of Vulnerable Population Status on Patient Outcomes

Vulnerable populations in health care include the economically disadvantaged, racial and ethnic minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals; rural individuals who may have trouble accessing care; and those with stigmatized chronic conditions such as severe mental illness or human immunodeficiency virus (HIV).[4] These populations may be more likely to suffer from hunger and access to healthy food options, lack social and economic support, have lower education levels, live in unsafe neighborhoods devoid of parks and playgrounds, and often are subjected to discrimination.[5]

Vulnerable populations are less likely to have health coverage, struggle with health care access, and often have little interaction or trust in the health care system. They are less likely to receive preventive services and are more likely to go to the emergency department or hospital for a condition that might have been treated in a lower cost facility.[6] As a result, their medical interventions generally come much later and at significantly higher cost than for other populations. Moreover, lower income populations are twice as likely as those with higher incomes to have behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to experience food insecurity.[7] Additionally, there is considerable overlap in vulnerable populations. For example, Black and Hispanic American minorities are significantly more likely than Whites to be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and death rates.[8]

Though access to health care is essential for well-being, it is not the greatest health determinant.[9] Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more important determinants of early death than health care itself. Furthermore, there is a growing consensus that non-medical factors shape an individual's ability to engage in health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing.[10] Such environmental factors may have multi-generational impacts.

Generally, the current health care system is not built around the poorest and most vulnerable. Exacerbating the ability to effectively care for these populations is the fact that many physicians are not able to identify high-risk patients. Some of the current risk algorithms used by payers were

originally developed without access to electronic medical record (EMR) data, so many current predictive risk tools have limited utility. The link between non-medical factors and poor health outcomes is well-documented, but few traditional payment and delivery models are equipped to address these non-medical factors that drive high health care costs and poor outcomes.

Addressing the Unique Needs of Vulnerable Populations in Payment and Delivery

There are a growing number of initiatives to address SDHs and challenges unique to vulnerable populations within and outside of the health care system. These include multi-payer federal and state initiatives, Medicaid initiatives led by states or health plans, and physician-level activities focused on identifying and addressing the social needs of their patients. APMs can provide opportunities to cover services that can help provide care and support that vulnerable or high-risk populations need but that are generally not available under traditional payment models. Examples of such initiatives are highlighted below and include: Accountable Health Communities, the Chinese Community Accountable Care Organization (ACO), the Acute Unscheduled Care Model, and the Patient-Centered Opioid Addiction Treatment (P-COAT) APM.

Accountable Health Communities

In 2016, the Center for Medicare and Medicaid Innovation (CMMI), which was established by the Affordable Care Act, announced the Accountable Health Communities model, which is focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs.[11] The model provides funding to examine whether systematically identifying and addressing social needs of beneficiaries through screening, referral, and community navigation services affects health costs and reduces health care utilization. In 2017, CMMI awarded grants to organizations to participate in the model over a five-year period.[12]

Twenty awardees will encourage partner alignment to ensure that community services are available and open to the needs of beneficiaries. To implement the alignment approach, bridge organizations will serve as “hubs” in their communities that will identify and partner with clinical delivery sites to conduct systematic screenings of beneficiary health-related social needs and make referrals to community services that may be able to address the recognized social needs; coordinate and connect beneficiaries to community service providers through community service navigation; and align model partners to optimize community capacity to address these social needs.

The Chinese Community ACO

The Chinese Community ACO (CCACO) is a community-based physician-owned ACO that serves about 12,000 Medicare fee-for-service (FFS) beneficiaries in the Chinese communities in New York City.[13] The aim of the model is to reduce overall health care costs and disparities by identifying high-risk individuals and undertaking proactive disease management. The CCACO establishes a network of organizations by partnering with hospitals, nursing homes, home health agencies, senior centers, and others to facilitate coordinated care. The model anticipates that, due to care coordination efforts, it will prevent emergency room visits and hospital readmissions in this population.

Acute Unscheduled Care Model (AUCM) Enhancing Appropriate Admissions from the American College of Emergency Physicians (ACEP)

The AUCM was developed by the ACEP. The particular payment model was submitted to the PTAC, and the PTAC subsequently recommended to the Secretary of HHS that the model be

implemented. It centers on incentivizing improved quality and decreased costs associated with the discharge decisions made by emergency department (ED) physicians.[14] The model proposes that it may reduce Medicare spending and improve quality care by reducing avoidable hospital inpatient admissions and observation days by giving ED physicians the ability to coordinate and manage post-discharge home services. The model is a bundled payment, and the episode of care begins with a qualifying ED visit and ends after 30 days or with the patient's death.[15] All of the Medicare services received within that 30-day window are included in the bundle. To assist in care transformation efforts, the model also uses several waivers in order to allow ED physicians to offer telehealth services, bill for transitional management codes, and permit clinical staff to offer home visits.

Patient-Centered Opioid Addiction Treatment (P-COAT) APM

The P-COAT model is a payment model created jointly by the American Society of Addiction Medicine (ASAM) and the AMA. The model proposes to manage opioid use disorder, a highly stigmatized condition, by increasing utilization of and access to medications for the treatment of opioid use disorder by providing the appropriate financial support to successfully treat patients and broaden the coordinated delivery of medical, psychological, and social supports.[16] The current payment system offers little support for the coordination of behavioral and social supports that patients being treated for opioid use disorder need. Therefore, under P-COAT, treatment teams are eligible to receive two new types of payments that would be expected to provide the necessary financial support to enable providers to deliver the appropriate opioid addiction treatment.[17]

AMA POLICY

The AMA has a wealth of policy on both APMs and SDH. Regarding APMs, Policy H-385.913 promulgates goals for physician-focused APMs, develops guidelines for medical societies and physicians to begin identifying and developing APMs, encourages the Centers for Medicare & Medicaid Services (CMS) and private payers to support assistance to physician practices working to implement APMs, and states that APMs should account for the patient populations, including non-clinical factors. Policy H-385.908 states that the AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to control or influence, will work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage, access to health care services, and socio-demographic factors.

Moreover, AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs. Policy D-390.953 directs the AMA to advocate with CMS and Congress for alternative payment models developed in concert with specialty and state medical organizations. Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients and directs the AMA to advocate for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions. Policy H-450.961 states that incentives should be intended to promote health care quality and patient safety and not primarily be intended to contain costs, provide program flexibility that allows physicians to accommodate the varying needs of individual patients, adjust performance measures by risk and case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support access to care for all people and avoid selectively treating healthier patients. Additionally, Policy D-35.935 supports physician-led, team-based care delivery recognizing that the interdisciplinary care team is well equipped to provide a whole-person health care experience.

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to exercise leadership aimed at addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports while Policy H-160.896 calls to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

Recognizing that current risk adjustment and performance measure systems may disincentivize caring for the most vulnerable, Policy H-450.924 supports that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing hospitals, including safety net hospitals, and physicians that may exacerbate health care disparities.

AMA ACTIVITY

The AMA continues to work to aid physicians in the implementation of MACRA and by encouraging and enabling physician participation in APMs. The AMA has been active in educational activities including webinars and regional conferences for physicians and staff and will be continuing these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs. Such areas for improvement in methodology include performance targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies enable more physicians to participate in APMs and promotes design of APMs in such a way that prioritizes the patient's need.

The AMA continues to strive to ensure that all communities of Americans receive equal access to quality health care. The AMA is committed to working toward the goal of all Americans having access to affordable and meaningful health care. It is addressing this issue systemically by striving for health equity by mitigating disparity factors. For example, the AMA has developed numerous resources including a Health Disparities Toolkit that helps connect physicians and care teams to chronic disease prevention programs in the community. The AMA STEPSForward™ module entitled Addressing Social Determinants of Health describes how a practice can select and define a plan to address SDH issues. Additionally, steps toward health equality are being taken in the AMA's effort toward creating the medical school of the future. Within the AMA's Accelerating Change in Medical Education (ACE) initiative, some medical schools are incorporating education on disparities within their curricula while others are addressing diversity in the health care workforce by changing admissions and pipeline programs to ensure that our nation has the diverse workforce that it needs.

Additionally, the AMA is integrating SDH into its Integrated Health Model Initiative (IHMI), a collaborative effort that supports a continuous learning environment to enable interoperative technology solutions and care models that evolve with real world use and feedback. IHMI's

collaborative platform is discussing SDH with the goal of identifying those factors that should be incorporated into the IHMI data model. Moreover, the IHMI team has delivered a module that incorporates two of the widely accepted SDH: the nine-digit Zip Code™ where one lives and those who are dually-eligible for Medicaid and Medicare.

Importantly, the AMA recognizes that health quality can only happen in concert with efforts to improve physician satisfaction and wellbeing. Therefore, the AMA is helping create an engaged workforce and mitigating burnout. To that end, the AMA has developed STEPSForward™ resources and Burnout Assessment Tools to allow physicians to assess their practices and find ways to leverage their entire care team to improve physician and patient experience and care. The AMA knows that advocating for physicians and patients is critical to achieve health equity. Patients and the public are partners in the quest for equitable access to quality health and health care.

Moreover, the AMA is establishing a new Health Equity Center with the goal of enabling optimal health for all with an eye on social justice. The Center will serve as a demonstration of the AMA's long-term and enduring commitment to health equity.

DISCUSSION

Heath care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. Because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, several studies have demonstrated that value-based payment programs disproportionately penalize physicians serving the poorest and most vulnerable populations, possibly disincentivizing physicians from caring for them. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council notes that reaffirming existing AMA policies helps to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients. The current health care system was not built for vulnerable populations, and they remain woefully underserved. Therefore, the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations and believes that PFPMs provide an excellent opportunity to transform care delivery to better meet the needs of underserved populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of

health. The Council is steadfast in its belief that the structure and quality reporting of APMs must protect against penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. Furthermore, because of the Council's commitment to this principle, the Council believes that the topic of risk adjustment warrants revisiting and notes that at the 2019 Interim Meeting, it will present a report specifically addressing ways in which risk adjustment methodology and implementation can be improved.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 712-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)

2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)

3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (New HOD Policy)

4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one means to reduce disparities in health care. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing that they play a critical role as bridgebuilders between underserved communities and the health care system and calling for sustainable funding mechanisms to financial CHW services. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and social services and supports. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 11 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Corporate Investors
(Reference Committee G)

EXECUTIVE SUMMARY

While the extent of corporate investment in physician practices is not precisely known, growing numbers of physicians are employed by corporations including hospitals, health systems and insurers. Increasingly, private equity firms have also acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician experiences and opinions vary.

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues; loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians' financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.

Longstanding AMA policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. This report recommends a series of guidelines that should be considered by physicians who are contemplating corporate investor partnerships; supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; and encourages further study by affected national medical specialty societies.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 11-A-19

Subject: Corporate Investors

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-383.979, "Corporate Investors." This policy states that our American Medical Association (AMA) will study, with report back at the 2019 Annual Meeting, the effects on the health care marketplace of corporate investors (e.g., public companies, venture capital/private equity firms, insurance companies and health systems) acquiring a majority and/or controlling interest in entities that manage physician practices, such as the degree of corporate investor penetration and investment in the health care marketplace; the impact on physician practice and independence; patient access; resultant trends in the use of non-physician extenders; long term financial viability of practices; effects of ownership turnovers and bankruptcies on patients and practice patterns; effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces; and the relative impact corporate investor transactions have on the paths and durations of junior, mid-career and senior physicians.

This report describes physician practice consolidation with corporate investors, including private equity investment in physician practices; discusses the corporate practice of medicine; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation among health care entities, including consolidation involving physician practices, is closely monitored by the AMA. An array of factors—including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens—have driven some physicians to be employed by, merge with or join hospitals, health systems and insurers. Increasingly, private equity partnerships/firms, which pool funds to invest in companies with the goal of running them more efficiently and selling them at a profit, have also acquired majority and/or controlling interests in entities that manage physician practices.

While the extent of corporate investment in health care is not precisely known, increasing numbers of physicians are employed by corporations, including hospitals, health systems and health insurers.[1] Data from the 2018 Health Care Services Acquisition Report demonstrates corporate investor interest in physician practices. The report documented that 2017 saw the highest annual number of transactions (166 deals) involving physician medical groups since 1998 (264 deals). Of the 10 largest physician medical group transactions completed between 2013 and 2017, two were acquisitions of large physician groups by UnitedHealth's Optum unit, and another two involved private equity firms. Many of the largest transactions involved public companies.[2]

The long-term trend away from physicians being practice owners and toward physicians being employees has been documented via the AMA's Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians providing at least 20 hours of patient care. These surveys, conducted biennially, have found that physician ownership dropped by seven percentage points (from 53.2 percent to 45.9 percent) between 2012 and 2018.[3] Notably, the year 2018 was the first time that the percentage of physician owners was less than the percentage of physician employees (47.4 percent).[4]

Private Equity Investment in Physician Practices

Private equity firms, which acquire equity in businesses with funds from private investors, vary in terms of size, structure, business model and investment thesis. Venture capital is typically used to invest in emerging or early stage businesses such as start-ups. Buyout or leveraged buyout firms typically invest in mature or later-stage businesses, often taking a controlling interest.

Private equity investment in dermatology, radiology, anesthesiology, urology, gastroenterology, cardiology, orthopedic, radiology and ophthalmology practices, among other specialties, has garnered substantial publicity and attention from the physician community. Growth in the demand for health care services, coupled with an aging population and the development of innovative treatments, have made the health care sector attractive to private equity investors. Globally, total disclosed value of deals in the sector exceeded $63 billion in 2018, the most since 2006, with much of this activity concentrated in North America and the US in particular.[5] Providers and related services, including physician practice management, accounted for the most deals in 2018, with increased activity observed in anesthesia, radiology and behavioral health.[6] A reported 84 private equity deals involving providers (including but not limited to physician practices) were consummated in 2018, totaling $23 billion.[7] Private equity firms have also invested in hospitals, ambulatory surgical centers, retail health, health information technology (IT), home care and hospice, among many other services.[8]

Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity firms for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise.

Because many private equity transactions are not disclosed (nondisclosure agreements are commonly used during negotiations),[9] the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is in fact a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace. That said, there is evidence that physician practices are being acquired, not only by private equity firms but also by hospitals, health systems, academic medical centers, insurers, and large physician groups. Transactions involving private equity investors are occurring with some regularity. Consequently, affected physician specialties are attempting to understand these practice shifts as well as the risks and benefits of this practice model.

Dermatology is one such specialty, having experienced a surge in private equity deals involving dermatology-related practices in the last three to five years. Fifteen percent of recent private equity/physician practice transactions have been "dermatology-related," although dermatologists make up only one percent of US physicians.[10] As noted in a recent commentary in *JAMA Dermatology*:

> Consolidation of practices fueled by private equity investments has begun to transform dermatology … Existing dermatologists are encouraged to stay after the sale through equity stakes or deferred payouts, but in some cases, the investors may accept departures because the buyout recipients can sometimes be replaced by younger dermatologists or physician assistants who are paid at a lower level.[11]

Private equity firms have also shown interest in ophthalmology practices, as described in *Review of Ophthalmology*:

> The basic premise is that a private equity firm offers to form a partnership with an ophthalmology practice that it believes has the potential to grow. It provides funding to the practice owners, including an upfront payment in cash and/or stock, in exchange for a percentage of future profits. Ultimately, the goal is to increase the value of the practice by investing in its growth—often partly by consolidating it with other practices—so that in a few years it can be resold to another private equity firm for a significant profit.[12]

Noted researcher Lawrence Casalino, MD, et al. described the phenomenon as follows:

> These investors anticipate average annual returns of 20 percent or more. To achieve such returns, private equity firms focus on acquiring "platform practices" that are large, well managed, and reputable in their community. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with the larger practice, increasing revenue (for example, by bringing pathology services into a dermatology practice), and decreasing costs (for example, by substituting physician assistants for physicians). Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.[13]

A recent *JAMA Viewpoint* concluded:

> Even though consolidation may create economies of scale and layoffs and other cost-cutting measures may reduce operating costs, increased market power over price negotiations with insurers and boosting volume for ancillary revenue streams may increase spending. Empirical analysis is needed to understand the net consequences and to compare spending among private equity-owned, hospital-owned, and independent practices.[14]

Risks and Benefits of Partnering with Corporate Investors

There is little peer-reviewed evidence regarding the impact of corporate investors on physicians, physician autonomy, patients or health care prices. Anecdotal information suggests an increase in the use of non-physician extenders by some private equity firms and other challenges facing physicians working for practices affiliated with private equity firms. The experiences of practices entering employment arrangements with hospitals, health systems, academic medical centers and insurers may differ from private equity investors because these entities function in the health care marketplace and frequently have existing physician leadership in place. Additionally, in contrast to private-equity backed practices, hospitals, health systems and academic medical centers may use some of their revenues to provide uncompensated care and/or contribute to medical education and training.[15]

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues;

loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians' financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.[16] Importantly, corporate investors are obviously not all the same and may differ significantly in terms of their business models and culture. Some are centralized and physician-led, while others are centralized but not physician-led; the degree of physician autonomy in decision making also varies.

AMA ACTIVITY

In monitoring mergers and acquisitions, the AMA's position is that each health care entity consolidation must be examined individually, taking into account case-specific variables related to market power and patient needs. AMA policy strongly supports and encourages competition in all health care markets to provide patients with more choices while improving care and lowering the costs of that care. Markets should be sufficiently competitive to allow physicians to have adequate practice options. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large systems can be an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.[17]

The AMA promotes physician leadership in integrated structures and has developed policies and resources intended to help safeguard physicians employed by large systems. The AMA has also developed several resources intended to help physicians understand employment contracts. These include the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Group Practice Employment Agreement, and the Annotated Model Physician-Hospital Employment Agreement as well as a Making the Rounds podcast on contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed the guide Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called "Unwinding Existing Arrangements" that guides employed physicians on how to "unwind" from their organization, factoring in operational, financial, and strategic considerations.

At the time that this report was written, the AMA was planning to release, mid-year in 2019, resources related to venture capital and private equity investments that highlight the main issues physicians may encounter when engaging with such firms, including modifications to compensation, investment in infrastructure, how to evaluate contractual agreements, and hands-on management. A related checklist was also planned that will offer specific considerations such as terms-of-sale for the practice, standardization techniques and economies of scale, and unwinding terms.

Corporate Practice of Medicine

The term "corporate practice of medicine" encompasses complex legal issues that may mean different things to different people and vary widely by state. The corporate practice of medicine

can, for example, prohibit a lay corporation from practicing medicine or employing physicians, or prohibit non-physicians or lay organizations from having an ownership interest in a physician practice. The doctrine is based on concerns that: (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine; (2) a corporation's obligation to its shareholders may not align with a physician's obligations to his or her patients; and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgement.[18]

As delivery systems and physician employment arrangements have evolved over the years, so too has the corporate practice of medicine doctrine. The health care environment is shifting toward increased integration of care, with growth in both the number of employed physicians and acquisitions of physician practices. These trends have led to formalized employment relationships between physicians and non-physician entities, arrangements that in certain states may run afoul of corporate practice of medicine policies. Council on Medical Service Report 6-I-13 addressed the corporate practice of medicine.

RELEVANT AMA POLICY

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. Under Policy D-225.977, the AMA continues to assess the needs of employed physicians, ensuring physician clinical autonomy and self-governance. Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective care. Antitrust relief is a top AMA priority under Policy H-380.987.

AMA Principles for Physician Employment are outlined in Policy H-225.950. Policy H-225.997 addresses physician-hospital relationships, and Policy H-225.942 outlines physician and medical staff rights and responsibilities. Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. Truth in advertising is addressed by Policies H-410.951 and H-405.969.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, "Principles for Physician Employment," discourage

physicians from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients' choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

Policy H-140.984 opposes an across-the-board ban on self-referrals because of benefits to patients including increased access to competition, and includes standards to ensure ethical and acceptable financial arrangements. This policy states that the opportunity to invest in the medical or health care facility established by a health care services financial arrangement should be open to all individuals who are financially able and interested in an investment.

DISCUSSION

The Council's study of corporate investors acquiring majority and/or controlling interest in entities that manage physician practices was hindered by the lack of empirical evidence regarding the impact of these practice models on physicians, patients, medical practice, and the costs and quality of care. Although anecdotal information is available from affected specialties, there is not sufficient data to draw meaningful or actionable conclusions. Nonetheless, the Council underscores the paramount importance to this discussion of safeguarding patient-centered care, clinical governance and physician autonomy in all physician practice arrangements, including those involving corporate investors.

The Council also believes it is worth noting that physician opinions vary regarding corporate investor involvement in physician practices. Although there has been a great deal of angst among many physicians regarding private equity investments in practices, other physicians and physician groups have readily partnered with these firms. Long-standing policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit, and it is essential that the AMA maintain a leadership role that is uniting and supportive of all physicians and care delivery models.

The Council recommends, therefore, reaffirmation of four existing AMA policies—on the corporate practice of medicine, financial incentives, physician employment, and corporate ownership of private medical practices—that are relevant to corporate investor relationships with physician practices. Because physicians appear to be looking for guidance and solutions, the Council also recommends a series of guidelines that it believes should be considered by physicians who are contemplating corporate investor partnerships.

As previously noted, nondisclosure agreements are commonly used in private equity and corporate investor transactions, and the Council believes that more information is needed regarding the degree of corporate investment in physician practices and what this means for health care prices. The lack of complete and accurate information may prevent health care markets from operating efficiently and preclude patients from making informed decisions regarding low-cost, high-value care. Accordingly, the Council recommends supporting improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.

The Council recognizes that further study is needed on the impact of corporate investors, and recommends encouraging national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and physicians.

Finally, the Council recommends rescinding Policy D-383.979, which led to the development of this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-215.981, which opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-225.950, which affirms that a physician's paramount responsibility is to his or her patients, and which outlines principles related to conflicts of interest and contracting. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of medical care. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. (Reaffirm HOD Policy)

5. That our AMA encourage physicians who are contemplating corporate investor partnerships to consider the following guidelines:

    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.

g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. (New HOD Policy)

6. That our AMA support improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices. (New HOD Policy)

7. That our AMA encourage national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty. (New HOD Policy)

8. That our AMA rescind Policy D-383.979, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Corporate Practice of Medicine H-215.981
1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. 2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. 3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. b) Physicians should never be coerced into employment with hospitals, health care systems,

medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts. c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs. b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of

their employment agreements, nor be retaliated against by their employers, for asserting these interests. d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.
5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings. b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status. c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians. d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment. e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc. (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.
6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement. b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Financial Incentives Utilized in the Management of Medical Care H-285.951
Our AMA believes that the use of financial incentives in the management of medical care should be guided by the following principles: (1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. (2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. (3) Financial incentives should enhance the provision of high quality, cost-effective medical care. (4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients. (6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment. (7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment. (11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments. (13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

Corporate Ownership of Established Private Medical Practices H-160.960
When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-19)

Introduced by: Delaware

Subject: Coding for Prior Authorization Obstacles

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Many patients are insured by third-party payers which require prior authorization before testing and therapies can be performed by a medical professional; and

Whereas, The prior authorization process may become arduous and time consuming causing delay in the performance of testing and therapies; and

Whereas, Many times the prior authorization process cannot be completed in a timely manner causing or contributing to the morbidity or mortality of the patient; and

Whereas, The physician is required to identify processes which primarily caused and secondarily contributed to the demise of a patient; therefore be it

RESOLVED, That our American Medical Association support the establishment of ICD codes that cover and fully describe prior authorization processes and any and all other administrative and bureaucratic obstacles that may cause or in part contribute to a patient's morbidity or mortality by both delay, as well as denial, of services. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 03/18/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-19)

Introduced by: Young Physicians Section

Subject: Peer Support Groups for Second Victims

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Our AMA has extensive policy on medical student, resident, and physician stress and burnout and suicide; and

Whereas, In medical malpractice cases, dealing with the plaintiff's attorneys can make it difficult for health care workers to know what to do, and who they can talk to, professionally or legally; and

Whereas, When there is an adverse event in health care, there is often a "culture of silence," in which defense lawyers ask healthcare workers not to discuss the case outside of work because of various legal implications (including potential HIPAA violations); and

Whereas, Second victims are defined as "a health care provider involved in an unanticipated patient event, a medical error, and/or a patient-related injury and become victimized in the sense that they are traumatized by the event"[1]; and

Whereas, Commonly-reported symptoms of second victim phenomenon include fatigue, sleep disturbances, frustration, difficulty concentration, flashbacks, decreased job satisfaction, grief/remorse, and loss of confidence; and

Whereas, High-risk scenarios for second victim phenomenon include medical errors, death experiences, unexpected patient demises, and unexpected connections between patients and one's family members; and

Whereas, There is some evidence that peer support groups for second victim phenomenon may be helpful for healthcare workers; and

Whereas, The issues of stress, burnout, and second victim phenomenon are likely to impact our physician workforce in the near and distant future; therefore be it

RESOLVED, That our American Medical Association encourage institutional, local, and state physician wellness programs to consider developing peer support groups to address the "second victim phenomenon" (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other interested organizations to develop a survey of all physicians in the United States to quantitate the effects of stress and burnout on them, and its potential impact on our physician workforce. (Directive to Take Action)

Fiscal Note: Estimated cost of $465,000 to implement resolution.

Received: 04/04/19

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RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
Citation: (CME Rep. 8, A-07; Modified: Res. 919, I-11

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16

Study of Medical Student, Resident, and Physician Suicide D-345.984
Our AMA will: (1) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action; and (2) request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.
Citation: Res. 019, A-18; Appended: Res. 951, I-18

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are

outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18

Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993
Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.
Citation: Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Preservation of the Patient-Physician Relationship

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The patient-physician relationship is among the most important elements of our medical profession; and

Whereas, The quality of the patient-physician relationship is crucial to the care of the patient, improving the value of the patient-physician encounter to both parties and greatly enhancing the chances that the patient's concern can be met; and

Whereas, Dr. Bernard Lown, in his book "The Lost Art of Healing: Practicing Compassion in Medicine" states that "the three thousand year tradition which bonded doctor and patient in a special affinity of trust is being traded for a new type of relationship; healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technology;" and

Whereas, Dr. Lown's observations are more relevant now than ever before as a result of: (1) increasing time constraints on physicians due to scheduling issues; (2) the intrusion of electronic devices in the consultation room, which can make sustained eye contact between the patient and his/her physician more challenging; and (3) curriculum changes in some medical schools such that history-taking and examination skills are not emphasized as they once were; and

Whereas, As physicians, we owe it to our patients and ourselves to do everything we can to preserve the patient-physician relationship; therefore be it

RESOLVED, That our American Medical Association, in an effort to improve professional satisfaction among physicians while also enhancing patient care, conduct a study to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, as well as identify healthcare work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim Meeting. (Directive to Take Action)

Fiscal note: Modest: Between $1,000 - $5,000.

Received: 04/12/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-19)

Introduced by: Delaware

Subject: Prior Authorization Reform

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, In February 2019 the AMA released results of its 2018 Prior Authorization Physician Survey[1] showing that 28 percent of physicians indicated the prior authorization process required by health insurers has led to serious or life-threatening events for their patients; and

Whereas, 91 percent of the physicians responding to the AMA prior authorization survey indicated the prior authorization process delays patient access to necessary care; and

Whereas, 88 percent of the respondents to the AMA prior authorization survey believe burdens associated with prior authorization have increased during the past five years; and

Whereas, The AMA prior authorization survey illustrates that prior authorization programs and processes are costly, inefficient, and pose obstacles to patient-centered care; and

Whereas, The current prior authorization process is in need of reform so patients receive timely access to evidence-based care; and

Whereas, The prior authorization process in Delaware mirrors the challenges reflected in the 2018 AMA Prior Authorization Physician Survey; and

Whereas, The Medical Society of Delaware (MSD) is leading a groundbreaking initiative to utilize emerging technology to reduce the arduous process of prior authorization, improve access to care for patients, and reduce unnecessary health care spending; and

Whereas, MSD is now prepared to launch a pilot program in the State of Delaware designed to test and validate such new technology; and

Whereas, Our American Medical Association, a national medical association, is best positioned to drive reform and improvement of the prior authorization process; therefore be it

RESOLVED, That our American Medical Association explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/24/19

[1]American Medical Association. “2018 AMA Prior Authorization (PA) Physician Survey.” Survey. December 2018.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-19)

Introduced by: Thomas J. Madejski, MD, Delegate

Subject: Physician Requirements for Comprehensive Stroke Center Designation

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The government is moving to credential hospitals as different level stroke centers and would then direct ambulances to divert patients to these hospitals; and

Whereas, Much of the focus for such diversion would be a hospital's ability to provide mechanical thrombectomy service; and

Whereas, Mechanical thrombectomy is a relatively straightforward endovascular procedure that is infrequently performed as part of successful stroke management--for example a hospital that sees 1000 patients per year as a "rule out stroke" might actually only have 500 stroke patients, and only 20 patients who qualify for mechanical thrombectomy, of which only 10 will potentially do well after the thrombectomy; and

Whereas, Some of the planned requirements for these stroke center designations, such as from The Joint Commission, are arbitrary, and unduly burdensome, and not based on sound scientific evidence such as:

(a) Doctors who perform fewer than 15 thrombectomies per year would no longer be eligible to cover call

(b) Doctors covering endovascular services could only cover one hospital at a given time; and

Whereas, There are no studies available that establish a distinct threshold for a volume – outcome relationship in regards to mechanical thrombectomy; and

Whereas, These stringent requirements will unnecessarily disqualify most endovascular procedurists -- endovascular neurosurgeons, endovascular neurologists, and endovascular neuro-radiologists -- from continuing to work, as they will not be able to perform 15 thrombectomies per year; and

Whereas, The Society for Interventional Radiology sponsored an independent analysis of the Centers for Medicare and Medicaid Services' thrombectomy data from 2016 that showed that 85% of physicians who billed this code, billed it 10 times or fewer, and of the 15% of physicians who performed the procedure more than 10 times that year, the median number was 15; that is to say, most physicians who were performing the procedure, would not meet the stringent volume requirement; and

Whereas, There is no reason that a doctor could not cover more than one hospital at a time for a procedure that is straightforward, brief, and will likely be performed at even a busy hospital no more than once per week; and

Whereas, These unusually stringent requirements will actually prevent most hospitals from achieving appropriate stroke center designations, and will thus lead to having all neurological volume diverted away from their ER's, leading paradoxically to potential stroke patients being diverted long distances for care when such care was readily available nearby; therefore be it

RESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements:

1) Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and

2) Stroke procedurists should be able to take call at more than one hospital at a time. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-19)

Introduced by: Wisconsin

Subject: Hospital Falls and "Never Events" - A Need for More in Depth Study

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Concerns regarding gaps in medical quality and patient safety led The Joint Commission in 1996 to identify serious patient safety events (such as patient death, permanent harm to a patient, or temporary harm to a patient requiring immediate intervention to sustain the patient's life) as "Sentinel Events" that warrant immediate investigation and remediation to prevent their recurrence; and

Whereas, The National Quality Forum (NQF) expanded such analysis of serious patient safety events to develop its list of "Never Events," events that could occur during the process of offering medical care that should be expected to never happen, such as wrong-sited surgery; and

Whereas, Payors of health care services, including the Center for Medicare and Medicaid Services (CMS) and major commercial payors, have determined that insurance claims for entire episodes of care should be denied if, in the course of that care episode, a "never event" occurred; and

Whereas, The 2016 list of "Never Events" (referred to formally as "Serious Reportable Events") compiled by the NQF, includes "Patient death or serious injury associated with a fall while being cared for in a health care setting;" and

Whereas, Out of sincere concern for the safety of patients, and out of concern regarding adverse publicity should a "never event" occur, and out of concern that reimbursement could be significantly impacted adversely were a "never event" to occur, hospitals are diligent about educating their staff about "never events" on the NQF list and how to avoid them; and

Whereas, Our current system of "keeping score" of falls has created a disincentive for mobilizing patients and consequently increases patients' risk for falls due to deconditioning effects of bed rest;[1] and

Whereas, Nursing staff in hospitals are understandably afraid for what may happen to patients or to themselves as licensed health professionals and as employees were there to be a patient fall resulting in serious injury or patient death, and have become hypervigilant, to assure that patients do not experience falls in the healthcare setting;[2,3] and

Whereas, "Driving in fear" has been shown to be counterproductive to the generation of improved overall results in patient safety and health care outcomes; and

Whereas, A result of nursing staff fear has been demonstrated to be an increase in efforts of nursing staff to keep patients in bed and to not get up and move about, lest a fall occur,

including the use of bed and chair alarms, which further restrict mobility, to notify staff should a patient get up;[3-7] and

Whereas, Restricting mobility has been shown to directly cause loss of muscle mass and strength[8] and increase fall risk in older adult patients[9], and is associated with Hospital-Acquired Disability[10] and are counterproductive to patients restoring their functional abilities after an illness or injury leads to a hospitalization; and

Whereas, Limiting older adult patient mobility during a hospital stay results in post-hospital syndrome[11] and trauma of hospitalization[12], increasing risk for adverse health events such as falls post discharge,[13] new nursing home placement,[14] mortality,[14] decrease quality of life and readmission within 30 days;[15] and

Whereas, The Wisconsin State Journal, the daily newspaper in the state's second largest city, published a three-part Special Report in March 2019, supported by a journalism fellowship from the Gerontological Society of America, Journalists Network on Generations and the John A. Hartford Foundation, reporting that Wisconsin leads the nations in falls, in fatal falls, and falls in health care institutions, and highlighting research in the nursing professional literature that accreditation standards intended to prevent falls can have counterproductive effects; and

Whereas, It has been demonstrated through research by the University of Wisconsin's Barbara King, RN, PhD, and others that patients' functional abilities during a hospitalization and in the weeks or months after hospital discharge are diminished quantitatively and over longer spans of time when patients have been kept in bed longer rather than assisted to get up and reestablish mobility sooner;[16-19] and

Whereas, It has been demonstrated through an impact assessment of CMS "never events" that the CMS policy on falls has actually had no salutary effect on the rates of injurious falls;[20] therefore be it

RESOLVED, That our American Medical Association study the merits of recommending that "Patient death or serious injury associated with a fall while being cared for in a health care setting" be removed from the list of "Never Events" for which a hospital may face an adverse payment decision by third-party payors or an adverse accreditation decision by The Joint Commission (Directive to Take Action); and be it further

RESOLVED, That our AMA study the merits of recommending that a pay-for-performance measure be added which would reward health care organizations for taking steps resulting in patients' improved ability to participate in self-care, improved functional status, and improved mobility for seniors who have been admitted to a facility for a condition resulting in a temporary need for bed rest. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/01/19

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-19)

Introduced by: Illinois

Subject: Cost of Unpaid Patient Deductibles on Physician Staff Time

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Physicians in the U.S. are faced with increased administrative burdens and burnout related to new payment models from insurance companies and regulations from the federal government that already lead to less time with their patients; and

Whereas, These new models also put more burdens on patients in the form of higher out-of-pocket costs as employers, health insurance companies and government health programs move to higher deductible health plans; and

Whereas, These high deductibles woven into insurance contracts with providers are creating a new and growing administrative burden for physicians when the doctor is forced to track down the unpaid portion of the care not covered by the health plan; and

Whereas, Because the size and scope of the deductible is created by the insurance company in their contract, the physician shouldn't be forced to spend physician and practice staff time tracking down a portion of a payment created by the health plan's reimbursement formula. That should be the responsibility of the insurance company; and

Whereas, The percentage of large employers offering a high deductible health plan is projected to increase from 80% in 2018 to 92% in 2019, according to a survey of 170 large employers by the National Business Group on Health; and

Whereas, Four in ten, or 39%, of employers offer a high-deductible plan as the only option for their workers, the same National Business Group on Health survey shows; and

Whereas, The American Hospital Association reports uncompensated care costs are rising in part due to patients paying higher out-of-pocket costs from high deductibles. In 2016, the AHA's most recent report, shows uncompensated care costs rose to $38.3 billion in 2016 from $35.7 billion in 2015; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that brings an end to insurance company practices that make it the physician's responsibility to recoup patient out-of-pocket costs and deductibles created by health plans. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-19)

Introduced by: American Association for Geriatric Psychiatry
American Psychiatric Association

Subject: Access to Psychiatric Treatment in Long-Term Care

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, A mission of our AMA is to better public health; and

Whereas, Our AMA supports the provision of access to, and improved treatment for millions of Americans who suffer from mental illness and substance use disorders, as well as help to prevent such conditions; and

Whereas, Our AMA advocates 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 (H-25.999, “Health Care for Older Patients”); and

Whereas, That the Centers for Medicare & Medicaid Services (CMS) created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes without attention to the mental health needs of consumers and without input from psychiatric physicians; and

Whereas, The use of psychotropic medications as a factor contributing to the Nursing Home Compare ranking creates a disincentive to accept individuals with mental health diagnoses into nursing homes, encourages discriminatory housing practices (in violation of the Fair Housing Act) and promotes inferior treatment practices for those with mental health diagnoses (in violation of the Americans with Disabilities Act) by incentivizing discontinuation of needed treatment of those mental health conditions with or without dementia; therefore be it

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness (Directive to Take Action); and be it further

RESOLVED, That our AMA ask CMS to discontinue the use of psychotropic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications (Directive to Take Action); and be it further

RESOLVED, That our AMA ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed (Directive to Take Action); and be it further

RESOLVED, That our AMA ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

Reference:

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RELEVANT AMA POLICY

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.
3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.
4.Our AMA recognizes the impact of violence and social determinants on women’s mental health.
Citation: Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17

Long-Term Care Prescribing of Atypical Antipsychotic Medications H-25.989
Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare."
Citation: Res. 819, I-11

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995
Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement.
Citation: (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-15

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.
Citation: Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18

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.
Citation: CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18

Access to Mental Health Services D-345.997
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.
Citation: CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Modified: Res. 503, A-17

Statement of Principles on Mental Health H-345.999
(1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.

(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.
Citation: (A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09

Drug Regimen Review in Long Term Care Settings H-280.963
The AMA: (1) supports physician involvement in drug utilization review in long term care settings and encourages CMS to recognize that the evaluation and management services of the medical director (MD/DO) of the long term care facility can reduce drug expenditures, fraud and overutilization while assuring quality medical care; (2) encourages CMS to conduct well-designed research into medication uses in nursing facilities and the clinical outcomes of drug therapy; and (3) will work closely with the American Medical Directors Association and other appropriate organizations to improve outcomes of drug therapy in nursing homes and to encourage CMS to review the issue of appropriate professional resources needed to provide optimal prescription use in nursing facilities.
Citation: Res. 105, A-94; Reaffirmed and Appended by Res. 502, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

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..
Citation: (Committee on Aging Report, I-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation A-11; Appended: Res. 709, A-13

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis.
Citation: Res. 523, A-12;

Drug Regimen Review in Long Term Care Settings H-280.963
The AMA: (1) supports physician involvement in drug utilization review in long term care settings and encourages CMS to recognize that the evaluation and management services of the medical director (MD/DO) of the long term care facility can reduce drug expenditures, fraud and overutilization while assuring quality medical care; (2) encourages CMS to conduct well-designed research into medication uses in nursing facilities and the clinical outcomes of drug therapy; and (3) will work closely with the American Medical Directors Association and other appropriate organizations to improve outcomes of drug therapy in nursing homes and to encourage CMS to review the issue of appropriate professional resources needed to provide optimal prescription use in nursing facilities.
Citation: Res. 105, A-94; Reaffirmed and Appended by Res. 502, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis.
Citation: Res. 523, A-12;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-19)

Introduced by: American Association of Neurological Surgeons
Congress of Neurological Surgeons

Subject: Promoting Accountability in Prior Authorization

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The use of prior authorization (PA) by health insurance companies has increased significantly over the past years; and

Whereas, According to a recent study released by our AMA nearly all (86%) physicians report that the burdens associated with PA are high or extremely high, with physicians spending the equivalent of two business days (14.9 hours) each week completing PAs; and

Whereas, In that same study, 91% of physicians report care delays, 75% state that PA can lead to treatment abandonment and 28% report that PA led to a serious adverse event such as death or disability; and

Whereas, Physicians increasingly must go through a “peer-to-peer” review process before a health plan makes a final PA determination, and typically the so-called peer is not a physician or is not a physician of the same medical specialty/subspecialty as the prescribing/ordering physician; and

Whereas, There is a lack of transparency and accountability with the peer-to-peer review process; and

Whereas, Individuals serving as reviewers for health plans are practicing medicine and serving as experts and should, therefore, be licensed to practice medicine and held to the same ethical standards as physicians rendering patient care or providing expert witness testimony in medical-legal proceedings; therefore be it

RESOLVED, That American Medical Association Policy H-320.968, “Approaches to Increase Payer Accountability,” be amended by addition and deletion as follows:

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or

contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA ~~supports~~ advocate for the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a utilization review entity or health plan be of the same specialty and have expertise to treat the medical condition or disease as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above. (Modify HOD Policy); and be it further

RESOLVED, That the AMA and its Council on Judicial and Ethical Affairs, study the ethical and medicolegal responsibilities of physicians who participate in the prior authorization process on behalf of utilization review entities or health plans, particularly with regard to determinations of medical necessity, and report back to the HOD at the 2020 Annual Meeting with guidance for physicians who provide utilization review services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

RELEVANT AMA POLICY

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.
(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.
(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.
Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13 , I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-19)

Introduced by: Michigan

Subject: Council for Affordable Quality Healthcare Attestation

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The Council for Affordable Quality Healthcare (CAQH) is a single data repository which maintains information about physicians for credentialing; and

Whereas, Physicians are being asked to resubmit their data every 120 days to maintain credentialing on this site even if none of the relevant information has changed; and

Whereas, Resubmission requires actual data submission, not just confirmation of existing data; and

Whereas, Even confirmation of existing data should not require verification every 90 to 120 days; and

Whereas, Confirmation of data every 120 days is not an industry standard for any similar credentialing process, such as for third party payers or for hospital medical staff requirements; and

Whereas, The need to continue this process places an unnecessary burden on physicians without any clear indication for this ongoing request; therefore be it

RESOLVED, That our American Medical Association work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

RELEVANT AMA POLICY

Licensure and Credentialing Issues D-275.995
Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.
Citation: Res. 303, I-00; Reaffirmation A-04; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 3, I-14

Verifying Physicians' Credentials H-275.977
The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept.
Citation: (Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, The performance analysis results for Medicare Shared Savings Accountable Care Organizations (ACOs) show lower savings for hospital integrated systems as opposed to physician-owned systems; and

Whereas, The system infrastructure costs needed to form ACOs have resulted in many physician practices being taken over and consolidated by hospital-owned systems; and

Whereas, The fact that hospital integrated systems generated lower savings or even higher costs compared to those savings realized by physician-owned groups is a major concern; and

Whereas, CMS is advocating for ACOs to move to the Next Generation model by taking on downside risk as the major route to participate in alternative payment models; and

Whereas, This will be attempted in an environment where the savings of hospital integrated systems are not financially significant–placing physicians in those systems at increased risk for practice failure or loss of their positions through compensatory staff reductions; and

Whereas, The majority of Medicare Shared Savings Program ACOs have decided not to move to the Next Generation model based upon the aforementioned economic inadequacies; and

Whereas, Hospital integrated systems that have failed to generate significant savings are under pressure to either downsize medical staffs or take over the involved health care system entirely, leading to further consolidation–an even worse scenario driven in some situations by financial entities with no previous commitment to, or involvement in, medicine; and

Whereas, Efforts to downsize the medical staff are not only demoralizing, but may also diminish the medical staff's governance functions with each subsequent consolidation–an effect that is most extreme among the physicians involved in hospital integrated systems; therefore be it

RESOLVED, That our American Medical Association study: (1) the effect of hospital integrated system ACOs' failure to generate savings on downsizing of the medical staff and further consolidation of medical practices; and (2) the root causes for failure to generate savings in hospital integrated ACOs, as compared to physician-owned ACOs, and report back at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 05/09/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-19)

Introduced by: Society of Critical Care Medicine

Subject: Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

Whereas, Early recognition and treatment of Sepsis saves lives (1); and

Whereas, The CDC has launched the "Get Ahead of Sepsis" campaign to increase public awareness of sepsis and the importance of early recognition of sepsis to reduce related mortality and morbidity… (2); and

Whereas, The "Surviving Sepsis Campaign," a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine whose mission is to reduce mortality and morbidity from sepsis and septic shock worldwide, recommends that early identification and treatment using a bundle of interventions increases the likelihood of survival from sepsis (3); and

Whereas, Promotion of early screening and diagnosis of Sepsis by primary care physicians and other health care providers that practice outside of hospital settings may avoid delay in treatment and improve patient outcomes (4) yet continues to be an area of opportunity to improve sepsis care from a population health approach (3); and

Whereas, Healthcare providers will be empowered by improved knowledge and early use of tools for Sepsis screening to help make a difference in preventing patients from progressing to organ failure; therefore be it

RESOLVED, That our American Medical Association collaborate with interested medical organizations such as the Centers for Disease Control and Prevention and the Society of Critical Care Medicine to promote the importance of early detection and expedited intervention of sepsis by healthcare providers who work in out-of-hospital settings to improve patient outcomes and save lives. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

References:
(1) https://www.cdc.gov/features/get-ahead-sepsis/index.html
(2) CDC. "CDC urges early recognition, prompt treatment of sepsis". CDC. 31 August 2017. Available at (2) https://www.cdc.gov/media/releases/2017/p0831-sepsis-recognition-treatment.html
(3) http://www.survivingsepsis.org/About-SSC/Pages/default.aspx
(4) CDC. Available at https://www.cdc.gov/sepsis/what-is-sepsis.html.
(5) https://www.nice.org.uk/guidance/NG51

RELEVANT AMA POLICY

Improved Treatment of Sepsis H-160.898
Our AMA: (1) supports innovations and public awareness campaigns that facilitate the early recognition and treatment of sepsis in pediatric and adult populations; and (2) believes that medical screening, diagnosis, and treatment protocols for sepsis should not be mandated by governmental entities in the absence of substantial scientific consensus.
Citation: Res. 522, A-17

Informational Reports

BOT Report(s)

03 2018 Grants and Donations

05 Update on Corporate Relationships

06 Redefining AMA's Position on ACA and Healthcare Reform

07 AMA Performance, Activities and Status in 2018

08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019

CC&B Report(s)

02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws

CEJA Opinion(s)

01 Amendment to E-2.2.1, "Pediatric Decision Making"

CEJA Report(s)

04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

05 Discrimination Against Physicians by Patients

CLRPD Report(s)

01 Demographic Characteristics of the House of Delegates and AMA Leadership

CME Report(s)

05 Accelerating Change in Medical Education Consortium Outcomes

07 For-Profit Medical Schools or Colleges

CSAPH Report(s)

02 Drug Shortages: 2019 Update

Report of the Speakers

01 Recommendations for Policy Reconciliation

REPORT OF THE BOARD TRUSTEES

B of T Report 3-A-19

Subject: 2018 Grants and Donations

Presented by: Jack Resneck, Jr., MD, Chair

This informational financial report details all grants or donations received by the American Medical Association during 2018.

American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2018
Amounts in thousands

Funding Institution	Project	Amount Received
Agency for Healthcare Research and Quality (subcontracted through Northwestern University)	Midwest Small Practice Care Transformation Research Alliance	$ 141
Agency for Healthcare Research and Quality (subcontracted through RAND Corporation)	Health Insurance Expansion and Physician Distribution	67
Centers for Disease Control and Prevention (subcontracted through National Association of Chronic Disease Directors)	Diabetes Technical Assistance and Support	156
Centers for Disease Control and Prevention (subcontracted through YMCA)	Diabetes Prevention Program	71
Centers for Medicare & Medicaid Services	Transforming Clinical Practices Initiative — Support and Alignment Networks	549
National Institutes of Health (subcontracted through HCM Strategist, LLC)	All of Us Research Program	64
Substance Abuse and Mental Health Services Administration (subcontracted through American Academy of Addiction Psychiatry)	Providers Clinical Support System for Opioid Therapies	69
Government Funding		**1,117**
American Association of Colleges of Osteopathic Medicine	Accelerating Change in Medical Education Initiative	13
American Heart Association, Inc.	Target: Blood Pressure Initiative	94
American College of Emergency Physicians	Accelerating Change in Medical Education Initiative	13
Nonprofit Contributors		**120**
Contributions less than $5,000	International Medical Graduates Section Reception	5
Other Contributors		**5**
Total Grants and Donations		**$ 1,242**

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-A-19

Subject: Update on Corporate Relationships

Presented by: Jack Resneck, Jr., MD, Chair

PURPOSE

The purpose of this informational report is to update the House of Delegates (HOD) on the results of the Corporate Review process from January 1 through December 31, 2018. Corporate activities that associate the American Medical Association (AMA) name or logo with a company, non-Federation association or foundation, or include commercial support, currently undergo review and recommendations by the Corporate Review Team (CRT) (Appendix A).

BACKGROUND

At the 2002 Annual Meeting, the HOD approved revised principles to govern the American Medical Association's (AMA) corporate relationships, HOD Policy G-630.040 "Principles on Corporate Relationships." These "Guidelines for American Medical Association Corporate Relationships" were incorporated into the corporate review process, are reviewed regularly, and were reaffirmed at the 2012 Annual Meeting. AMA managers are responsible for reviewing AMA projects to ensure they fit within these guidelines.

YEAR 2018 RESULTS

In 2018, eighty new activities were considered and approved through the Corporate Review process. Of the 80 projects recommended for approval, 33 were conferences or events, nine were education, content or grants, 24 were collaborations or affiliations, 12 were member service provider programs, one was an American Medical Association (AMA) Alliance activity and one was an American Medical Association Foundation (AMAF) program. (Appendix B).

CONCLUSION

The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk assessment with the need for external collaborations that advance the AMA's strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions Group (HSG), Advocacy, Federation Relations, Office of the General Counsel, Medical Education, Publishing, Ethics, Enterprise Communications (EC), Physician Engagement (PE), and Health and Science.

The CRT evaluates each project with the following criteria:

- Type, purpose and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA logo;
- Fit or conflict with AMA Corporate Guidelines;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.

- AMA sponsorship of external events.

- Independent and company-sponsored foundation supported projects.

- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or CPT licensing.)

- Member service provider programs such as new affinity or insurance programs and member benefits.

- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.

- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.

- Collaboration with academic institutions only if there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds.

In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.
- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees. The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2018

Project No.	Project Description	Corporations	Approval Date
CONFERENCES/EVENTS			
22738	**TEDMED 2018** – Continue TEDMED conference sponsorship with name and logo	TEDMED, LLC	6/5/2018
23524	**HIMSS18 Annual Conference –** Sponsorship with AMA name and logo.	Health Information and Management Systems Society (HIMSS)	1/9/2018
27797	**Sandy Hook Gala Event 2018 –** Continue sponsorship with AMA name and logo.	Sandy Hook Promise Akin Gump Straus Hauer & Feld, LLP Amalgamated Bank Anthem, Inc. Blue Cross Blue Shield Association Genentech, Inc. Heather McHugh Liberty Partners Group, LLC Managed Funds Association Mehlman Castagnetti Rosen & Thomas National Association of Broadcasters (NAB) National Multifamily Housing Council Pacific Gas & Electric Company (PG&E) The Sorenson Family Diageo, PLC Wine and Spirits Wholesalers of America, Inc. Aetna Inc. Air Line Pilots Association (ALPA) American Health Care Association (AHCA) AT&T Inc. (American Telephone and Telegraph) The Bank of America Corporation Boehringer-Ingelheim, GmbH CVS Health (Consumer Value Store) Deloitte Touche Tohmatsu Limited Discovery Communications, Inc. Lockheed Martin Corporation Lumina Foundation	4/6/2018

		Merck & Co., Inc. Verizon Wireless Charter Communications, Inc. S&P Global Inc. (Standard & Poor) PepsiCo, Inc. Comcast Corporation Centene Corporation Pharmaceutical Research and Manufacturers of America (PhRMA) Alexion Pharmaceuticals, Inc. General Dynamics Corporation Association for Accessible Medicine	
27981	**Alliance for Health Policy –** Continue sponsorship of event dinner with AMA name and logo.	Pharmaceutical Research and Manufacturers of America (PhRMA) Health Is Primary (Family Medicine for America's Health) Aetna, Inc. Anthem Insurance Companies, Inc. Ascension Health Blue Cross Blue Shield Association Cambia Health Foundation GSK (GlaxoSmithKline) Welsh Carson Anderson & Stowe (WCAS) Bristol-Myers Squibb Company (BMS) Amgen, Inc. (Applied Molecular Genetics) Association of Community Affiliated Plans (ACAP) Novartis International, A.G. Biotechnology Innovation Organization (BIO) Blue Shield of California DaVita, Inc. UCB, Inc. (Union Chimique Belge) Vertex Pharmaceuticals, Inc.	5/11/2018
29472	**Sling Health 2018 Demo Day** – Sponsorship with AMA name and logo.	Sling Health National Network Pharmaceutical Research and Manufacturers of America (PhRMA) Husch Blackwell, LLP The Boston Consulting Group, Inc. (BCG) Cortex Innovation Community St. Louis Metropolitan Medical Society St. Louis Regional Chamber	4/10/2018

		Barnes-Jewish Christian HealthCare (BJC) Inventr InSite Washington University in St. Louis St. Louis Development Partnership Penn HealthX University of Michigan Medical School EVNTUR Cambridge Innovation Center (CIC) Louisiana State University Health (LSU Health) Foundation Brown Smith Wallace, LLP	
29760	**8th Annual Diversity Inclusion and Health Equity Symposium** – Sponsorship with AMA name and logo.	Center for Healthcare Innovation (CHI) Genentech, Inc. Abbott Laboratories Edelman Digital AbbVie, Inc. Salesforce, Inc. West Monroe Partners, LLC. The University of Chicago Medicine Gilead Sciences, Inc. Northwestern University Upsher-Smith Laboratories, LLC Drinker Biddle & Reath LLP Aurora Health Care Sanofi, S.A. SoPE (Society of Physician Entrepreneurs) Chiltern International Limited	5/9/2019
29938	**2018 Personal Connected Health (PCH) Alliance Conference –** Continue sponsorship with AMA name and logo.	Connected Health Conference Personal Connected Health (PCH) Alliance	6/25/2018
31205	**2018 25th Annual Princeton Conference –** Sponsorship with AMA name and logo.	Princeton University	1/22/2018
31322	**AMA Global Health Challenge** – AMA to rebrand Timmy Global Health Challenge as AMA Global Health Challenge.	Timmy Global Health Med Plus Advantage International Medical Group (IMG)	2/8/2018
31368	**AMA Sponsored Journalist Training on Opioid/Addiction Epidemic** – AMA sponsorship of training program for journalists.	American Society of Addiction (ASAM) National Press Foundation (NPF)	2/19/2018

31391	**2018 Women Business Leaders in Healthcare (WBL) Summit –** Sponsorship with AMA name and logo.	Women Business Leaders in Healthcare (WBL) Tivity Health, Inc. MCG Health, LLC, part of the Health Network UnitedHealth Group, Inc. Medecision, Inc. American Mobile Nurses (AMN) Healthcare McKesson Corporation Tabula Rasa Healthcare Catholic Health Initiatives Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. Amgen, Inc. Highmark, Inc. Trustmark National Bank Healthcare Leadership Council (HLC) Navigant Consulting, Inc. Dobson DaVanzo & Associates, LLC	2/13/2018
32602	**Northern Connecticut and Western Massachusetts Juvenile Diabetes Research Foundation (JDRF) Annual Promise Ball –** AMA sponsorship with name and logo.	Northern Connecticut and Western Massachusetts Juvenile Diabetes Research Foundation (JDRF) Optum, Inc. Travelers (The Travelers Indemnity Company) Aetna, Inc. Aspen RE (Reinsurance) Cigna (Global Health Service Company) HealthPlan Services, Inc. Mandell Family Foundation (Foundation Center) Accenture, Inc. Convey Health Solutions Pratt & Whitney (United Technologies Corporation) Travelers Championship (The Greater Hartford Community Foundation) Bartlett, Brainard, Eacott (BBE) Inc. Covington & Burling, LLP Prudential Financial, Inc. The Hartford Financial Services Group, Inc. Klynveld Peat Marwick Goerdeler (KPMG) International Cooperative Barnes Group, Inc. Concentrix Corporation Hartford Yard Dogs (Minor League Baseball Team)	

		Lilly Diabetes (Lilly USA, LLC) Marcum Accountants (Marcum LLP) New Britain Bees (Atlantic League of Professional Baseball Team) New England Development, Inc. PRO Unlimited, Inc. People's United Bank, N.A.	
32603	**National Minority Quality Forum Leadership Summit 2018 –** Sponsorship with AMA name and logo.	National Minority Quality Forum, Inc.	4/2/2018
32761	**AMA Physician Innovation Network (PIN)/Health:Further Conference Collaboration –** Speaking opportunity for AMA Physician Innovation Network (PIN) with AMA name and logo at Health: Further Conference.	Health:Further	5/4/2018
32899	**Big Data and Healthcare Analytics Forum –** Sponsorship with AMA name and logo.	Big Data and Healthcare Analytics Forum Health Information and Management Systems Society (HIMSS) Media, LLC Purestorage, Inc. General Electric (GE) Microsoft Corporation DataRobot, Inc. Sirius Healthcare (Sirius Computer Solutions, Inc.) 3M (Minnesota Mining and Manufacturing Company) Qlik Healthcare (QlikTech International AB) American Health Information Management Association (AHIMA) HealthDataViz, LLC Roche Diagnostics Information Solutions (F. Hoffmann-La Roche Ltd)	5/21/2018
33070	**American Health Information Management Association (AHIMA)/AMA Clinical Documentation Improvement (CDI) Summit –** AMA to co-brand and sponsor the summit with AHIMA.	Clinical Documentation Improvement (CDI) Summit American Health Information Management Association (AHIMA)	6/25/2018

33195	**2018 Connected Health Conference & Personal Connected Health (PCH) Alliance –** AMA to continue sponsorship with name and logo for 2018 event.	2018 Connected Health Conference Personal Connected Health (PCH) Alliance Health Information and Management Systems Society (HIMSS)	7/20/2018
33238	**2018 Midwest LGBTQ Health Symposium Reception –** Sponsorship of reception with AMA name and logo.	2018 Midwest LGBTQ Health Symposium Howard Brown Health Center for Education, Research and Advocacy	7/26/2018
33239	**2018 Health 2.0 Annual Fall Conference –** AMA to continue sponsorship with name and logo for 2018 event.	Health 2.0, LLC Health Information and Management Systems Society (HIMSS)	7/26/2018
33422	**National Association Medical Staff Services (NAMSS) Annual Meeting –** AMA name, logo and sponsorship of key (room) cards for meeting.	National Association Medical Staff Services (NAMSS)	8/24/2018
33423	**Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) Expo 2018 –** AMA to continue sponsorship with name and logo for 2018 event.	Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT)	8/24/2018
33424	**Health Information and Management Systems Society (HIMSS) Saudi Arabia Conference & Exhibition 2018 –** Sponsorship with AMA name and logo.	Health Information and Management Systems Society (HIMSS)	8/28/2018
33425	**Health Information and Management Systems Society (HIMSS) Big Data and Healthcare Analytics Forum –** Sponsorship with AMA name and logo.	Health Information and Management Systems Society (HIMSS) Initiate Government Solutions (IGS), LLC Rapid Insight, Inc.	8/24/2018
33428	**American Health Information Management Association (AHIMA) World Congress 2018 –** Sponsorship with AMA name and logo to reinforce CPT brand awareness internationally.	American Health Information Management Association (AHIMA) Cleveland Clinic Abu Dhabi 3M (Minnesota Mining and Manufacturing Company) Health Information Systems DML (Data Manipulation Language) Consulting, Inc.	8/28/2018
33479	**American Health Information Management Association (AHIMA) Annual Clinical Coding Meeting –** Sponsorship with AMA name and logo.	American Health Information Management Association (AHIMA)	9/4/2018

33494	**Predictive Analytics Innovation Summit –**Speaking engagement including sponsorship with AMA name and logo.	The Predictive Analytics Innovation Summit (The Innovation Enterprise Ltd) Visier, Inc. Women Who Code Decideo CrowdReviews, LLC Datafloq, B.V. Visibility Magazine	9/21/2018
33568	**2018 Chicago United –** Sponsorship with AMA name and logo for "Leaders for Change" 2018 gala event.	Chicago United	9/24/2018
33654	**HIMSS 2019 Agreement –** Collaboration for HIMSS Global Conference, with use of AMA name and logo.	Health Information and Management Systems Society (HIMSS)	10/5/2018
33672	**PCPI Fall Conference 2018 –** AMA IHMI sponsorship with AMA name and logo.	PCPI National Quality Registry Network (NQRN)	10/8/2018
33830	**Arab Health 2019 Conference –** Sponsorship with the AMA name and logo to establish CPT in Middle East healthcare market.	Arab Health (Informa Exhibitions, LLC)	10/31/2018
33859	**2019 National Rx Drug Abuse & Heroin Summit –** Sponsorship with AMA name and logo.	The National Rx Drug Abuse & Heroin Summit	11/2/2018
34034	**E-Health Conference 2019 –** Speaking engagement, booth and sponsorship with AMA name and logo to establish CPT in Canadian healthcare market.	Digital Health Canada Canada Health Infoway Canadian Institute for Health Information (CIHI)	11/13/2018
34269	**2019 National Quality Forum (NQF) Annual Conference –** Sponsorship with AMA name and logo.	National Quality Forum (NQF)	12/6/2018
EDUCATION, CONTENT OR GRANTS			
30540	**Gaples Institute for Integrative Cardiology Collaboration –** Gaples nutrition curriculum to be featured on the AMA Education Center.	Gaples Institute for Integrative Cardiology	12/6/2018
31526	**Validated Blood Pressure Device Criteria and Listing (VDL)** – Guidance to physicians on AMA/AHA Target:BP website regarding a	American Heart Association (AHA) National Opinion Research Center	4/23/2018

	list of devices demonstrating validation for clinical accuracy (VDL).		
31533	**"Distributed by" branding for American Medical Association / American Heart Association Target:BP Materials** – Listing of "distributed by Telligen" on AMA and AHA co-branded Target:BP materials.	American Heart Association (AHA) Telligen, Inc.	3/28/2018
32931	**American Hospital Association's Health Research and Educational Trust (HRET) –** AMA Improving Health Outcomes (IHO) royalty free license for diabetes prevention white paper development and dissemination.	Health Research and Educational Trust (HRET) American Hospital Association (AHA)	6/5/2018
33836	**American Hospital Association (AHA) and AMA "Blood Pressure Measure Accurately" Module –** AMA to co-create and co-brand education program to train primary care team members.	American Hospital Association (AHA)	10/31/2018
33885	**MedStar/AMA EHR Usability Comparison Research Microsite –** AMA name and logo use on EHR visibility website featuring videos.	Cerner Corporation Allscripts MEDITECH NextGen Epic (Electronic Privacy Information Center) Modernizing Medicine, Inc. CureMD Healthcare eClinicalworks Athenahealth, Inc. Kareo, Inc. General Electric (GE) Healthcare (Centricity)	11/5/2018
33896	**Physician Burnout Assessment Crosswalk Research -** AMA to distribute a physician burnout survey with incentive to physician population.	Amazon.com, Inc. The American Red Cross	11/2/2018
34154	**Target: BP Initiative Data Platform** – AMA/American Heart Association logo use on select pages of a chronic	American Heart Association (AHA) IQVIA, Inc	12/12/2018

	disease ambulatory platform with the vendor IQVIA.		
	2019 Historically Black Colleges and Universities (HBCU) Calendar and Resource Guide – Participation in calendar and resource guide.	Historically Black Colleges and Universities (HBCU)	7/12/2018
COLLABORATIONS/AFFILIATIONS			
25493	**Heka Health Collaboration –** Updated AMA collaboration on a self-measured blood pressure (SMBP) phone app pilot.	AllScripts Healthcare Solutions, Inc. Heka Health, Inc. eClinicalWorks	8/8/2018
30260	**AMA Physician Innovation Network (PIN) Collaborators –**AMA Physician Innovation Network (PIN) collaboration agreements with limited AMA name and logo use.	AngelMD, Inc. Physician Entrepreneur Summit Redox, Inc. Tincture.io Center for Digital Innovation (CDI-NEGEV) Further Fund Springboard Enterprises	9/13/2018
30327	**AMA IHMI Collaborators** – IHMI collaboration agreements with limited AMA name and logo use.	ACT - The App Association Elimu Medstro Association Forum Ingenious Med, Inc.	4/24/2018
31531	**AMA IHMI Google Innovation Challenge with Medstro –** Collaboration with Google and Medstro on the IHMI Google Innovation Challenge to enhance IHMI common data model.	Google, LLC Medstro	9/10/2018
32591	**AMA Physician Innovation Network (PIN)/Massachusetts Institute of Technology (MIT) Hacking Medicine Collaboration –** AMA Physician Innovation Network (PIN) to create a sub-community for Massachusetts Institute of Technology (MIT) Hacking Medicine events and workshops.	Massachusetts Institute of Technology (MIT) Hacking Medicine	4/2/2018
32732	**"All of Us" Precision Medicine Digital Physician Engagement Campaign –** AMA name and logo use to announce collaboration.	National Institute of Health (NIH) Figure 1	4/30/2018

32807	**American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) –** AMA support, name and logo for AFFIRM's steering committee. AMA not involved in fundraising.	American Foundation for Firearm Injury Reduction in Medicine (AFFIRM)	5/15/2018
32975	**AMA Physician Innovation Network (PIN)/Georgetown StartupHoyas Collaboration–** AMA Physician Innovation Network (PIN) to create a sub-community for Georgetown StartupHoyas.	Georgetown University School of Business	6/8/2018
33354	**FitGate Health Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	FitGate, Inc.	8/13/2018
33355	**Knowledge-Action-Change (KAC) Health Collaboration Agreement with IHMI** – IHMI collaboration agreement with limited AMA name and logo use.	Knowledge-Action-Change (KAC) Health, LLC	8/22/2018
33421	**AMA Digital Health Implementation Playbook –** AMA branded website with links to collaborator websites and newsletters.	Egg Strategy, Inc. Advocate Health Care, Inc. Avia, Inc. Baylor Scott & White Health Boston Medical Center (BMC) CareMore Health System (a subsidiary of Anthem, Inc.) Columbia University Medical Center Eccles School of Business Enlightening Results, LLC Epharmix, Inc. Inception Health, LLC Harvard Medical School Partners Healthcare Brigham and Women's Hospital Health2047, Inc. Healthbox, LLC HealthPartners Henry Ford Health System (HFHS) Illinois Gastroenterology Group/SonarMD, LLC Intermountain Healthcare IQVIA, Inc. John Hopkins Medicine (JHM)	8/30/2018

		Kaiser Permanente (Kaiser Foundation Health Plan, Inc.) Lucro Global, LLC Marshfield Clinic MassChallenge, Inc. Matter Health Mount Sinai Health System National Association of Community Health Centers NODE (Network of Digital Evidence) Health New York University (NYU) Langone Health Ochsner Health System OSF (Order of Saint Francis) Healthcare Partners Connected Health Partners HealthCare (Connected Health) Pharos Innovations, LLC Philips (Koninklijke Philips, N.V.) Privia Medical Group Providence Health & Services Rock Health Rx Health (Responsive Health) Samsung SLUCare Physician Group Stanford Health Care (SHC) The Dartmouth Institute The Research And Development (RAND) Corporation University of California San Francisco University of Colorado Health University of Mississippi Medical Center Penn Medicine (University of Pennsylvania Health System) University of Pittsburgh Medical Center Vivify Health, Inc.	
33446	**Propeller Health Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	Propeller Health	8/30/2018

33555	**Medfusion Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	Medfusion, Inc.	9/19/2018
33557	**PharmaSmart Collaboration Agreement with IHMI** - IHMI collaboration agreement with limited AMA name and logo use.	PharmaSmart International, Inc.	9/19/2018
33600	**PatientPoint Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	PatientPoint, LLC	9/27/2018
33627	**Prevention Strategy Collaboration with Health Care Organizations (HCOs) –** AMA name and logo will appear alongside these HCOs for national diabetes prevention program.	Marshfield Clinic Hattiesburg Clinic North Mississippi Health System Trinity Health Ascension Health, Inc. University of Florida Health Greenville Health System (GHS) Family Christian Health Center Loyola University Medical Center Matthew Walker Comprehensive Health Center, Inc. Mercy Community Health Care Riverbend Medical Group, Inc. University of Pittsburgh, PA (UPMC) Midwest Health's Midwest Heart & Vascular Specialists Aledade, Inc. Banner University Medical Center Harris Health System Health Management Services Organization Holy Cross Health Kelsey-Seybold Clinic Mercy Physician Network (Mercy Health System) Nashville University Priority Health Care South Illinois University Vanderbilt University Medical Center Wisconsin Women's Health Foundation Regents of the University of California University of Connecticut University of Michigan University of North Dakota	1/8/2018

		University of Pittsburgh Medical Center (UPMC) Community Medicine, Inc.	
33671	**Fitbit, Higi Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	Fitbit, Inc. Higi, SH, LLC	10/8/2018
33794	**NAM Opioid Action Collaborative –** AMA name, logo and sponsorship of public-private partnership to disseminate evidence based solutions to reduce opioid abuse.	National Academy of Medicine Action Collaborative (NAM Opioid Collaborative)	10/24/2018
33835	**Core Quality Measure Collaborative –** AMA participation and logo use in coalition to identify core sets of quality measures that payers will commit to use for reporting.	Core Quality Measure Collaborative (CQMC) National Quality Forum (NQF) The Centers for Medicare & Medicaid Services (CMS) AHIP (America's Health Insurance Plans)	10/25/2018
33884	**AMA Physician Innovation Network (PIN)/EHR Sub-Community –** AMA to display logos of organizations that agree to collaborate in an online community that connects physicians, vendors, healthcare and IT leaders on EHR best practices.	Cerner Corporation Allscripts Healthcare Solutions, Inc. MEDITECH (Medical Information Technology, Incorporated) NextGen Healthcare Information Epic Modernizing Medicine CureMD eClinicalworks Athenahealth Kareo General Electric (GE) Healthcare (Centricity) Cerner Corporation Allscripts	11/5/2018
33936	**TechSpring Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	TechSpring Health	11/7/2018
33988	**Persona Informatics Collaboration Agreement with IHMI –** IHMI collaboration agreement with limited AMA name and logo use.	Persona Informatics, Inc.	11/21/2018

34069	**The Collaborative for Healing and Renewal in Medicine (CHARM)** - The AMA logo will be associated with the Charter and the "CHARM" friends" on AMA and Arnold P. Gold Foundation websites.	The Collaborative for Healing and Renewal in Medicine (CHARM) Association of American Medical Colleges (AAMC) Society for Hospital Medicine Council of Residency Directors in Emergency Medicine Accreditation Council of CME (Continuing Medical Education) American College of Osteopathic Internists American Psychiatric Association National Hispanic Medical Association Institute for Healthcare Improvement Society for General Internal Medicine American College of Physicians ACLGIM (Association of Chief and Leaders of General Internal Medicine) National Medical Association AAIM (Alliance for Academic Internal Medicine) ABIM (American Board of Internal Medicine) American Society of Anesthesiology Arnold P. Gold Foundation	11/21/2018
	Partnership for America's Future Website logo request – AMA name and logo use to announce collaboration.	America's Health Insurance Plans (AHIP) Pharmaceutical Research and Manufacturer's Association (PhRMA) Biotechnology Innovation Organization (BIO) Blue Cross, Blue Shield Association (BCBS) Association of Accessible Medicines (AAM) Federation of American Hospitals	5/31/2018
MEMBER SERVICE PROVIDER PROGRAMS			
31423	**Mirador Financial Inc.** – AMA Affinity program for small practice lending services.	Mirador Financial, Inc. Core Innovation Capital Cuna Mutual Group Epic Ventures Collaborative Fund Jump Capital Crosslink Capital NYCA (New York Court of Appeals) Partners	2/27/2018

31459	**Relish Labs, LLC** – AMA Affinity program for home meal kits.	Relish Labs, LLC d/b/a Home Chef The Kroger Co.	6/13/2018
32694	**Laurel Road Bank–** AMA Affinity program for student loan refinance.	Laurel Road Bank (f/k/a Darien Rowayton Bank "DRB") Credible Labs, Inc.	4/25/2018
32786	**SimpliSafe, Inc. –**AMA Affinity program for security monitoring offices and homes.	SimpliSafe, Inc.	5/14/2018
33256	**Headspace, Inc. –** AMA Affinity program for discounted subscription to meditation and mindfulness mobile application.	Headspace, Inc.	8/14/2018
33257	**Gympass U.S., LLC –** AMA Affinity program for discounted fitness memberships.	Gympass U.S., LLC	8/6/2018
33258	**Intersections, Inc.** – AMA Affinity program for discounted identity theft protection and data breach readiness subscriptions.	Intersections, Inc. d/b/a Identity Guard	8/14/2018
33615	**GE Appliances** – AMA Affinity program for discounted home appliances.	General Electric (GE) Appliances Meridian One Corporation	10/3/2018
33615	**Meridian One Acquisition by Arthur J. Gallagher–** Arthur J. Gallagher purchases Meridian One, an AMA Affinity program partner for GE home appliances.	Meridian One Corporation Arthur J. Gallagher & Co. Gallagher Affinity	12/12/2018
33619	**Dell Marketing L.P. -** AMA Affinity program for discounted computer technology.	Dell Marketing L.P.	5/7/2018
33734	**AMA Affinity Hotel Program –** AMA Affinity program for international hotels.	Choice Hotels International, Inc.	10/3/2018
	AMA-sponsored Med Plus Advantage (MPA) with Employee Assistance Program – AMA Insurance Agency program for employee mental health counselling services through AMA-sponsored Med Plus Advantage (MPA) program.	Standard Insurance Company Morneau Shepell, Ltd.	9/24/2018

AMA ALLIANCE			
	AMA Alliance Video Program: "Community Approaches to Combat the Opioid Epidemic" – AMA Alliance and Independent Television News (ITN) Productions Industry News to co-brand and collaborate on an AMA Alliance promotional video, with AMA Alliance name and logo use.	AMA Alliance Independent Television News (ITN) Productions Industry News	5/7/2018
AMA FOUNDATION			
	AMA Foundation (AMAF) Corporate Roundtable Fundraising – Phase One – Phase one corporate fundraising campaign to increase AMA Foundation Corporate Roundtable members.	AbbVie, Inc. Actelion Pharmaceuticals US (J&J/Janssen Co.) Alexion Pharmaceuticals, Inc. America's Health Insurance Plans (AHIP) Amneal Pharmaceuticals, Inc. Argus Health Systems, Inc. AstraZeneca, PLC Biogen, Inc. BioMarin Pharmaceutical, Inc. Biotechnology Innovation Organization (BIO) Blue Cross Blue Shield Boehringer-Ingelheim, GmbH Bracco Diagnostics, Inc. Bristol-Myers Squibb Company Centene Corporation Cerner Corporation Change Healthcare Corporation Cigna Corp. Cigna Pharmacy Benefit Management Cipla USA, Inc. Citizens Rx, LLC CVS (Consumer Value Store) Caremark Daiichi Sankyo Company, Limited Eli Lilly and Company EnvisionRx Options (Envision Pharmaceuticals, LLC) Express Scripts Holding Company GE Foundation (General Electric) Genentech, Inc. Gilead Sciences, Inc. GlaxoSmithKline, PLC Henry Schein, Inc.	10/25/2018

		Horizon Pharma, PLC Humana, Inc. IBM Watson Health (International Business Machines) Incyte Corporation Insulet Corporation Ionis Pharmaceuticals Livongo Health, Inc. Lupin Pharmaceuticals, Inc. Mallinckrodt, LLC Masimo Corporation MedImpact Healthcare Systems, Inc. Merck and Company, Inc. MeridianRx, LLC Navitus Health Solutions Novartis International, AG Novo Nordisk A/S Oak Street Health, LLC Otsuka America Pharmaceutical, Inc. PerformRx, LLC Pernix Therapeutics Holdings Pfizer, Inc. Philips Healthcare Company Phoenix Benefits Management, LLC PhRMA (Pharmaceuticals Research and Manufactures) Prime Therapeutics, LLC ProCare RX Regeneron Pharmaceuticals, Inc. The Risk Authority – Stanford Sanofi Shionogi, Inc. Shire U.S. Solera Health (Solera Network) Sun Pharmaceutical Industries, Inc. Takeda Pharmaceuticals Company, LTD Terumo Medical Corporation Teva North America (Teva Pharmaceuticals, USA, Inc.) UnitedHealth Group, Inc. Vertex Pharmaceuticals, Inc. Walgreens (Walgreen Company) WellDyneRx, LLC World Wide Technology, Inc.	

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-A-19

Subject: Redefining AMA's Position on ACA and Healthcare Reform

Presented by: Jack Resneck, Jr., MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform," which called on our American Medical Association (AMA) to "develop a policy statement clearly outlining this organization's policies" on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, "Redefining AMA's Position on ACA and Healthcare Reform," accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

IMPROVING THE AFFORDABLE CARE ACT, AND AN UPDATE ON MEDICARE EXPANSION EFFORTS

Efforts are currently underway on Capitol Hill to enact polices to support the ACA and address recent efforts to weaken the law. The termination of cost sharing payments, for example, has increased premiums for those not eligible for the ACA's premium subsidies, resulting in significant decreases in enrollment among that population. In March, the House Committee on Energy and Commerce began efforts to enact legislation to support state reinsurance programs or to provide financial assistance to reduce out-of-pocket costs for those enrolled in qualified plans. Separate legislation would reverse cuts to the ACA Navigator program and expand program duties as they relate to Medicaid and the Medicare, Medicaid, Children's Health Insurance Program (CHIP). The committee will also consider legislation to again make funding available for the establishment of state-based marketplaces. The AMA remains engaged on this and other efforts to preserve current coverage options and make improvements where necessary.

Following the mid-term Congressional elections in 2018, a great deal of attention has been paid to efforts to enact legislation creating a Medicare for All program. As proposed, this single-payer system would replace the Affordable Care Act (ACA), CHIP and all private health insurance options available through employers or the individual market.

Our AMA is currently engaged in efforts with other partners across the health care sector to raise the awareness of the shortcomings of single-payer systems and, consistent with AMA policy, to continue to promote improvements to the current system which provides quality coverage to more than 90 percent of Americans while working to expand options to cover those who remain uninsured. Though polling on the general topic shows strong public support, that support quickly erodes when the details of a such a system are explained and people begin to comprehend the significant disruptions that would occur to the coverage and access to care they currently enjoy.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATIVE PAYMENT MODELS

Our AMA continues to work to make refinements to the Merit-based Incentive Payment System (MIPS) that was established by the Medicare Access and CHIP Reauthorization Act (MACRA). Work has proceeded through workgroups comprised of policy staff from state and national medical specialty societies as well as a CEO Working Group. At this writing, several policy modifications have been discussed which would not require statutory changes, while others would require Congressional action. Among proposals which can be implemented without Congressional action are:

- Keeping cost weighted at 15 percent for at least one additional year while new episode-based measures are developed and tested and phase in new measures.
- Ultimate elimination of the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures which double count costs and will potentially triple count costs once the cost-based episode measures are in place.
- Improve the accountability of cost measures so that physicians can make informed decisions about their cost effectiveness without being inappropriately penalized for care outside of their control or for caring for medically and socially complex patients.
- Reduce the requirements for reporting quality measures and propose a reporting option based on clinical continuums of care.
- Revise the quality measure benchmark methodology.
- Modify policies to encourage reporting via Qualified Clinical Data Registries (QCDRs).
- Increase transparency in the Improvement Activities category.
- Accept activity modifications and new activities on an accelerated timeline to reflect the pace of change in medicine.
- Allow multi-category credit for activities and measures that overlap performance categories to simplify the scoring methodology and make the program more clinically relevant.
- Propose (as opposed to seeking comment on) alternative scoring methodologies for promoting interoperability.
- Further simplify and reduce physician reporting burden through a yes/no measure attestation and leverage health IT vendors' reporting on utilization of Certified EHR Technology – Centers for Medicare & Medicaid Services (CMS) functionality.

Proposals which would likely require statutory changes by Congress include:

- Implement positive updates for physician payment rates for 2020-2025.
- Extend CMS' flexibility to set the performance threshold lower than the mean or median beyond 2021 performance year or permanently remove the "mean or median" requirement.
- Update the Promoting Interoperability category by including language that explicitly allows vendors as well as eligible professionals to submit the data necessary for eligible professionals to be considered a "meaningful user" and decouple the Promoting Interoperability performance category from the old EHR Meaningful Use program.
- Adopt a provision granting CMS explicit flexibility to base scoring on multi-category measures to reduce silos between each of the four MIPS categories and create a more unified program.
- Aid smaller practices by adding provisions that allow more flexibility for the development of virtual groups if CMS sees low numbers of physicians joining virtual groups in the first two years of the program.
- Remove the requirement that episode-based cost measures account for half of all expenditures under Parts A and B.

- Align benchmark/reporting language for the Quality performance category in MIPS and physician compare.

On March 1, 2019, the AMA wrote to Health and Human Services Secretary Alex Azar and CMS Deputy Administrator for Quality and Innovation Adam Boehler to put forth policy recommendations for HHS and CMS to consider as a means of generating more successful alternative payment models (APMs) that will achieve better outcomes for patients and more savings for Medicare. The recommendations fell into six policy areas:

- Limiting accountability to costs and outcomes that physicians can control;
- Making payment models simple but flexible;
- Providing physicians with the data needed to deliver high-value care;
- Encouraging the implementation of APMs developed by practicing clinicians;
- Trying multiple approaches to delivery and payment reform; and
- Extending MACRA APM incentives for a longer period.

Our AMA will continue to work with the Administration and Congress as appropriate to implement these and other steps that can improve the environment surrounding payment and delivery system reform efforts for physicians.

STEPS TO LOWER HEALTH CARE COSTS

As a follow up to multiple hearings over the summer of 2018, the Chairman of the Senate Committee on Health, Education, Labor and Pensions, Sen. Lamar Alexander of Tennessee, requested information from a broad range of stakeholders on specific steps that could be taken to reduce the cost of health care. In a March 1 response to the Chairman, the AMA put forth several recommendations.

One area in which the AMA made recommendations was the high administrative costs in the health care system, particularly related to burdensome prior authorization requirements and the enormous amount of physician and staff time spent in these tasks that add little to patient care and in many cases, delay medically necessary care. Other areas addressed to the committee were:

- Increased price and data transparency to empower patients;
- Prescription drug price and cost transparency;
- Value-Based Insurance Design;
- Alternative Payment Models; and
- Lowering health care costs with an increased focus on prevention, particularly the AMA's work on preventing diabetes and controlling hypertension.

CONCLUSION

Our AMA will remain engaged in efforts to improve the health care system through policies outlined in Policy D-165.938 and other directives of the House of Delegates.

REPORT 7 OF THE BOARD OF TRUSTEES (A-19)
AMA Performance, Activities and Status in 2018

EXECUTIVE SUMMARY

Solving the most urgent challenges in health care today - from the opioid epidemic to widespread system dysfunction - requires a bold vision, a creative approach and strategic partnerships across medicine, business and technology. The informational report "AMA Performance, Activities and Status in 2018" demonstrates the work of the American Medical Association in 2018 to be not only a strong unifying voice for the profession but an active and powerful ally for physicians and their patients across generations.

On an array of complex issues and challenges - from fighting abusive insurer practices and taking a stand on gun violence to advocating for greater drug pricing transparency and working to reform prior authorization burdens that often delay care - the AMA demonstrated its unsurpassed commitment to patients and physicians.

The AMA's groundbreaking efforts to reinvent medical education for the digital age took a sizable step forward in 2018 as we welcomed the first graduating classes from the AMA's "Accelerating Change in Medical Education" initiative. In addition, we introduced the next phase of our celebrated work with a "Reimagining Residency" initiative that promises to better train young physicians to meet the evolving needs of patients, communities and our dynamic health care system.

For the physician workforce of today, the AMA expanded its world-leading research journal with the launch of JAMA Network Open, a fully accessible online clinical research journal covering more than 40 key topics in medicine. It has quickly become an indispensable source for research and commentary on clinical care, health care innovation and global health.

This work was made possible thanks to another strong financial performance in 2018, which included increased membership for the eighth year in a row. Our membership growth is fueled by an innovative and award-winning campaign, "Membership Moves Medicine™," which grew membership by 3.4 percent in 2018, double the growth rate of the previous year.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-A-19

Subject: AMA Performance, Activities and Status in 2018

Presented by: Jack Resneck, Jr., MD, Chair

Policy G-605.050, "Annual Reporting Responsibilities of the AMA Board of Trustees," calls for the Board of Trustees to submit a report at the American Medical Association (AMA) Annual Meeting each year summarizing AMA performance, activities, and status for the prior year.

INTRODUCTION

The AMA's mission is to promote the art and science of medicine and the betterment of public health. As the physician organization whose reach and depth extends across all physicians, as well as policymakers, medical schools, and health care leaders, the AMA is uniquely positioned to deliver results-focused initiatives that enable physicians to answer a national imperative to measurably improve the health of the nation.

Attacking the dysfunction in health care

Insurer Practices

Abusive insurer practices continue to plague patients and physicians, but the AMA convinced Anthem to reverse course when Anthem announced a change in its modifier 25 policy that could have cost physician practices an estimated $100 million annually. The AMA also combatted Anthem/BCBS policies that deny coverage for emergency care, including supporting enactment of state legislation in Missouri.

The AMA created a consensus statement - adopted by industry stakeholders - to "right size" the prior authorization process.

- Supported by: AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and Medical Group Management Association
- AMA successfully collaborated to enact utilization management reforms (step therapy and prior authorization) in three states (IN, NM and WV)

The AMA's grassroots website, FixPriorAuth.org, launched in 2018 to educate the general public about the problems associated with prior authorization and to gather stories from physicians and patients about how they have been affected by it.

Physician Payment

Due to AMA advocacy, physicians averted an E/M code collapse that would have implemented dramatic reductions in physician payment. An AMA-convened physician workgroup developed a new E/M coding proposal to be considered by the CPT Editorial Panel in early 2019.

The AMA fought successfully for Congress to eliminate the Independent Payment Advisory Board.

CMS expanded coverage for services using telecommunications technology, strongly supported by the AMA.

AMA has been working with specialty societies and individual physicians to promote testing of new alternative payment models. Over the past 12 months, the federal Physician-focused Payment Model Technical Advisory Committee (PTAC) has recommended to the HHS Secretary five alternative payment models that were strongly supported by the AMA. These models aim to significantly improve care for patients that need emergency department care, oncology care, palliative care, advanced primary care, and those transitioning from chronic to end-stage renal disease. As AMA has strongly advocated, the CMS Innovation Center has indicated that it plans to implement three of these physician-focused payment models early in 2019.

AMA continued to successfully seek Quality Payment Program (QPP) improvements:

- Medicare Part B drug costs will be excluded from the Merit-based Incentive Payment System (MIPS) payment adjustments and from the low-volume threshold determination
- CMS may reweight the MIPS cost performance category to not less than 10 percent for the third, fourth and fifth program years (rather than requiring a weight of 30 percent in the third year)
- CMS has more flexibility in setting the MIPS performance threshold for years three through five to ensure a gradual and incremental transition to the performance threshold being set at the mean or median performance level in the sixth year

<u>Regulatory Relief</u>

The AMA secured significant improvements to the Promoting Interoperability component of the QPP (formerly known as the EHR Meaningful Use Program).

Congress eliminated the requirement that the federal electronic health record (EHR) program become more stringent over time.

<u>State efforts</u>

Working with state medical societies, the AMA helped secure over 85 state legislative and regulatory victories (issues include opioids, stabilizing the individual market, balance billing, Anthem ER policy, PBM regulation, utilization management, Medicaid expansion, banning of conversion therapy, scope of practice, medical liability reform, telemedicine, and more.)

<u>Practice Transformation (Operational)</u>

To support the operational components of physician practices, Professional Satisfaction and Practice Sustainability (PS2) relaunched, updated and expanded the STEPS Forward™ Practice Improvement Strategies collection as part of the AMA Ed Hub™, focused on creating the organizational structures that can result in more satisfied and productive physicians.

PS2 continues to partner with health systems, large practices, state medical societies, and graduate medical education programs to assess physician burnout utilizing the Mini-Z Burnout Assessment. Many of these burnout assessments were done in collaboration with the AMA's Physician Engagement unit as a key component of our offering for group membership.

The AMA, in partnership with Stanford WellMD and Mayo Clinic, led research to evaluate the latest trends in prevalence of burnout and satisfaction with work-life integration among physicians, to assess progress relative to 2011 and 2014 studies.

PS2 co-hosted a successful International Conference on Physician Health held October 2018 in Toronto with the Canadian Medical Association and British Medical Association, and will convene the second American Conference on Physician Health in Fall 2019 with our partners Stanford WellMD and Mayo Clinic.

In 2018, PS2 made a significant investment in research to expand the body of "practice science," championing evidence-based interventions to improve the delivery models of care at the practice and system levels. This robust body of research, entitled the AMA Practice Transformation Initiative (PTI), will be conducted in collaboration with heath systems, practices, and medical societies to study interventions at various practice types and sizes, with the goal of improving patient care by improving clinician satisfaction.

PS2 and Advocacy have partnered to provide new resources for physicians to provide clear guidance on commonly misunderstood regulatory guidelines that impact day-to-day clinical practice on pressing topics like Computerized Process Order Entry (CPOE) and Medical Student Documentation.

Digital Health (Technological)

PS2 continued to support the quadruple aim by convening the health care innovation ecosystem to advance the adoption of safe, effective electronic health records (EHRs) and digital health solutions - led by the physician and patient voice - in support of the quadruple aim.

PS2's work included the July 2018 publishing of "A Usability and Safety Analysis of Electronic Health Records: A Multi-Center Study" in the Journal of the American Medical Informatics Association. This followed the release of a guide with recommendations for improving the safety and usability of EHRs as well as safety test case scenarios.

PS2 continued to support and expand the influence of Xcertia, the collaboration dedicated to improving the quality, safety, and effectiveness of mobile health applications.

The AMA's Physician Innovation Network (PIN) continues to expand to amplify further the physician voice in health tech innovation by connecting physicians with health tech innovators and entrepreneurs.

PS2 launched the AMA Digital Health Implementation Playbook in Fall 2018 to improve the clinical integration and scaling of digital health tools. These tools, when leveraged effectively, can remove obstacles to delivering quality patient care and reduce physician burnout. The Playbook was brought to life with the support of over 30 collaborators, and it includes general best practices relevant for implementing any technology solution in practice as well as a chapter specifically focused on remote patient monitoring. The Playbook will be expanded in 2019 to include additional chapters emphasizing the implementation of additional specific digital health solutions.

Physician Payment and Quality (Financial)

The financial performance and sustainability of physician practices continues to be a focus of PS2's work to update our comprehensive collection of payment and quality reporting resources,

available on the AMA website, to reflect the current Medicare Quality Payment Program (QPP) program year.

In Fall 2018, the AMA and RAND Corporation partnered again to publish a follow-up study to our 2014 research on the effects of payment models on physician practices, hospitals and health plans. With this research, the AMA is positioned to better understand and shape alternative payment models and develop our strategic plan in this area to inform our investments in research, educational resources, and activities that enable physicians to adapt, lead and thrive in a value-based health care system.

A grant from the Centers for Medicare and Medicaid Services (CMS) Transforming Clinical Practices Initiative, through which the AMA is providing technical assistance and educational resources for multiple Practice Transformation Network (PTN) practices, was renewed for 2019. Under the auspices of the grant, the AMA will continue to convene experts to tackle the challenges associated with Qualified Clinical Data Registry reporting and quality measurement.

Litigation Center

Azar v. Allina Health Services: In 2018, the AMA Litigation Center filed an amicus brief before the US Supreme Court to argue for Medicare to use notice and comment rulemaking for significant payment rule changes.

Bell v. Mackey: A psychiatrist who discharged a patient who later committed suicide was shielded from liability under state law because the physician performed a good faith examination and favored his patient's autonomy vs. involuntary commitment. The Litigation Center filed a brief supporting the physician.

Mayo v. IPFCF: The Wisconsin Supreme Court upheld the constitutionality of Wisconsin's statutory cap on damages in medical malpractice suits. The Litigation Center filed an amicus brief in support of reinstating the cap.

Texas v. U.S.: The AMA filed an amicus brief defending the constitutionality of the ACA.

Tulare Hospital Medical Staff v. Tulare Local Healthcare District: The AMA supported the California Medical Association in reinstating a hospital medical staff and recovering certain damages after an unjust ousting from the hospital administration.

Sexual Orientation and Gender Identity (SOGI)

As directed by the House of Delegates, Policy G-635.125, asked the AMA, with input from the LGBTQ Advisory Committee, to expand the collection of demographic information from AMA members to include sexual orientation and gender identity. The initial roll-out of the SOGI data collection effort was successfully completed ahead of the 2018 AMA membership recruitment efforts and allows members and non-members to voluntarily submit SOGI information. Post-launch improvements were recently implemented to better capture and represent the diversity of the physician member population. The focus, now, will be to encourage participation and to develop a white paper on how the AMA implemented SOGI data collection for our members.

DMPAG

The Digital Medicine Payment Advisory Group made great progress towards its goal of integrating digital medicine technologies into clinical practice. This includes proposing new CPT codes for Remote Physiologic Monitoring and Interprofessional Internet Consultations. These codes were published in 2018 and will be covered and paid by Medicare and other payers in 2019.

CPT/RUC Workgroup

The CPT/RUC Workgroup on Evaluation and Management built a new coding structure for E/M Office Visit coding in response to changes to E/M proposed by CMS. The group has developed a consensus coding structure that will be proposed to the CPT Panel in February 2019. Given the progress made by the workgroup CMS has delayed implementation of any changes to E/M until 2021.

Reinventing medical education, training and lifelong learning

Beta launch of AMA Ed Hub

In 2018, the AMA introduced the AMA Ed Hub™ (amaedhub.com), AMA's new education delivery platform. Designed to support lifelong learning, licensure and certification needs, the AMA Ed Hub reflects the AMA's deep and longstanding commitment to lifelong professional development that helps physicians and the broader health care team achieve real-world outcomes of better health care and better health.

The AMA Ed Hub brings together the many excellent sources of education from across the AMA under one unified umbrella including JN Learning™, STEPs Forward™ and other AMA education. Serving as a powerful discovery channel for trusted education, the AMA Ed Hub provides physicians and other learners with simple, intuitive access to high quality education on any device, in many formats and at any time of the day. It delivers increasingly personalized learning experiences, serving up recommendations based on user interests and behaviors. It also features a consolidated learner transcript and seamless claiming, tracking and reporting of credit.

JAMA

The JAMA Network continued to expand into new channels and content types, such as podcasts (over 2.7 million downloads), Apple News feeds, and visual abstracts to increase the accessibility and reach of content for students, physicians, and researchers. This was highlighted by the launch of *JAMA Network Open* in 2018, the AMA's first online-only, fully open access clinical research journal. *JAMA Network Open* is a general medicine journal covering more than 40 topic areas, with the same commitment to quality and integrity as all the JAMA Network journals. In addition to content being freely available to all readers upon publication, *JAMA Network Open* aims to make content accessible to readers by including invited commentaries to put research in context, press releases, and article key points. As an online-only publication, *JAMA Network Open* will provide ongoing innovations around the publishing process and dissemination of content, which will benefit the entire JAMA Network as the landscape around scientific information continues to evolve.

Accelerating Change in Medical Education (ACE)

The major accomplishments of the ACE Consortium that work toward reimagining medical education, training, and lifelong learning for the digital age include:

- Celebrated the completion of the original five-year grant period
- All 32 consortium member institutions have committed to continue to collaborate, and will invite new members.
- Consortium innovations impact over 19,000 students throughout the US

A significant output of the consortium is the increasing incorporation of health systems science into medical education. Training in health systems science will prepare physicians to lead in another critical area of AMA's focus: *Attacking the dysfunction in health care by removing obstacles and burdens that interfere with patient care.*

- The Health Systems Science textbook, published by Elsevier in December 2016, has sold more than 4,300 copies and is used at more than two dozen academic institutions, both consortium and non-consortium members.
- The Health Systems Science Review book was completed in 2018 and will be published by Elsevier in April 2019.
- The consortium is developing the Health Systems Science Learning Series of online modules which will be used by medical students to learn health systems science topics.
- The inaugural Health Systems Science Faculty Development Workshop was held in September 2018 for medical school faculty to learn how to teach health systems science. Subsequent workshops are being planned.

The AMA awarded 15 Innovation grants of $10,000 to $30,000 to schools that will further the work to transform medical education.

The AMA announced the launch of and requested proposals for the Reimagining Residency Initiative. This $15 million program will provide grants to projects that will transform graduate medical education to better train young physicians to meet the changing needs of patients, communities and our dynamic health care system.

Journal of Ethics

The *AMA Journal of Ethics* website was completely redesigned and relaunched in July 2018, making it more user friendly and accessible. For example, educators of medical students or resident physicians are now able to filter and download content based on the ACGME core competencies or by medical specialty area.

Augmented Intelligence

In 2018, our House of Delegates approved a new policy outlining the use of augmented intelligence in health care and medicine. The policy outlines important considerations for design, evaluation, implementation and oversight of AI systems use in health care. The AMA remains committed to ensuring the evolution of AI occurs in a manner that benefits patients, their physicians, and the health care community.

Improving the health of the nation

Opioids

While the opioid epidemic continues to have a devastating effect on our nation, the AMA Opioid Task Force notes progress as the result of its efforts, including:

- Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million, or 22.2 percent.
- The number of physicians trained/certified to provide buprenorphine in-office continues to rise - more than 55,000 physicians are now certified - a 17,000+ increase since April 2017.
- Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 per week.
- More than 549,000 physicians and other health care professionals completed continuing medical education trainings and accessed other Federation education resources in 2017.

Congress provided nearly $4 billion for prevention, treatment and law enforcement efforts, and reached agreement on additional comprehensive legislation to address the opioid epidemic, including many provisions supported by the AMA.

AMA's intensive technical analysis and other support was used in more than 20 states to ensure state medical societies had current opioid prescribing and PDMP data to fight back against mandates and overly restrictive bills as well as strengthening naloxone access and Good Samaritan laws. This resulted in wins in at least 15 states in 2018 that are instrumental in reversing the opioid epidemic.

The AMA, along with Pennsylvania Medical Society and Manatt Health, conducted a spotlight analysis in Pennsylvania to demonstrate best practices on a state's response to the opioid epidemic and to highlight next steps. One of the key achievements in Pennsylvania includes a landmark agreement between the governor's administration and the seven largest insurers in the state, fully removing prior authorization requirements for medication-assisted treatment (MAT) to treat substance use disorder, and moving MAT to the lowest cost-sharing tier.

Access to Health Care

Congress provided funding for the Children's Health Insurance Plan for 10 years with strong AMA support.

Gun Violence

The AMA is working to prevent gun violence by partnering with the American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), a physician-led nonprofit organization that aims to counter the lack of federal funding for gun violence research by sponsoring gun violence research with privately raised funds, and pushing Congress to fund CDC gun violence research.

Drug Prices

With AMA support, Congress banned so-called gag clauses in contracts with insurers that prevented pharmacists from informing patients about less expensive options for purchasing their medications.

Liability

The AMA secured passage of Good Samaritan liability protections for physicians responding to health care needs in out-of-state disasters and emergencies.

Prediabetes Awareness

Prediabetes Campaign Refresh: In November 2018, the AMA in collaboration with the Centers for Disease Control and Prevention and the Ad Council launched a new creative edition to the national prediabetes public service (PSA) campaign. To date, more than one million people have self-screened for prediabetes thanks to the PSA campaign. Additionally, the national public awareness has increased by more than four percent since launching the national campaign two years ago.

Engagement with health care organizations

STAT Refresh: In December 2018, IHO launched a new digital Diabetes Prevention Guide that helps support health care organizations in defining and implementing evidence-based diabetes prevention strategies. Using a comprehensive and customized approach, this new digital experience brings AMA resources to health systems to help them identify patients with prediabetes and implement a type 2 diabetes prevention lifestyle change program that meets the needs of their unique patient populations.

Trinity Health System Collaboration: In 2018, the AMA engaged in a multi-state chronic disease prevention effort aimed at diabetes prevention with Trinity Health System, a national health system serving diverse communities in 93 hospitals in 22 states. Work includes assisting Trinity leadership in developing a strategic roadmap that engages physicians, care teams and residents, while also recognizing the need to create community linkages.

Target: BP**:** Over the past year, participation in the national Target: BP initiative - a joint endeavor with the American Heart Association that has a shared goal of improving blood pressure control to reduce the number of Americans who have heart attacks and strokes each year - increased to more than 1,600 health systems and physician practices nationwide. More than 8 million US adults are now being reached because of this national effort, which launched less than three years ago. In 2018, we recognized more than 800 physician practices that have made prioritizing blood pressure (BP) control for their patient populations a priority, with nearly 350 achieving a BP control rate above 70 percent.

Eminence/Research

PCORI Grant: In collaboration with a team of researchers from UCSF, the AMA's web-based version of our Blood Pressure M.A.P. QI program was selected to be tested as part of a three-year PCORI grant.

NACHC Grant: In collaboration with the Centers for Disease Control and Prevention (CDC) and the National Association of Community Health Centers (NACHC), the AMA was selected in October 2018 to help establish up to three health center control networks across the country that will leverage health information technology to address undiagnosed high blood pressure and cholesterol, improve blood pressure control in African Americans, and use self-measured blood pressure (SMBP) monitoring to improve blood pressure control in all adults with hypertension through 2019.

ACPM Grant: In collaboration with CDC and American College of Preventive Medicine (ACPM), the AMA was selected in October 2018 to help up to three health care organizations address the needs of disproportionately affected populations to identify adults with prediabetes and refer those with the condition to evidenced-based Diabetes Prevention Programs through 2019.

The IHO team published nine papers in leading journals including the *American Journal of Preventative Medicine, Hypertension, and International Journal of Healthcare*.

Communications

The AMA rose to the top of critical debates on immigration, gun violence, reimaging medical education and the future of health care. In 2018, the AMA media relations team secured 65,354 placements across national, local and trade media - coverage that generated more than 25 billion media impressions worth $232 million in estimated publicity value.

Membership

Membership grew for the 8th consecutive year, with a 3.4% increase in dues paying members in 2018, more than double the growth rate in 2017. Growth was fueled by an innovative and award-winning campaign, "Membership Moves Medicine™," which celebrates the powerful work of physician members and showcases how their individual efforts - along with the AMA - are moving medicine forward.

EVP Compensation

During 2018, pursuant to his employment agreement, total cash compensation paid to James L. Madara, MD, as AMA Executive Vice President was $1,107,042 in salary and $1,046,000 in incentive compensation, reduced by $2,890 in pre-tax deductions. Other taxable amounts per the contract are as follows: a $170,998 payment of prior years' deferred compensation, $14,478 imputed costs for life insurance, $7,620 imputed costs for executive life insurance, $2,500 paid for health club fees, $2,820 paid for parking and $3,500 paid for a physical. An $81,000 contribution to a deferred compensation account was also made by the AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred compensation agreement.

For additional information about AMA activities and accomplishments, please see the "AMA 2018 Annual Report."

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-A-19

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2018 through February 2019

Presented by: Jack Resneck, Jr., MD, Chair

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2018 through February 2019 and is written pursuant to AMA Policy D-490.983, "Annual Tobacco Report."

TOBACCO USE IN THE UNITED STATES: CDC MORBIDITY AND MORTALITY WEEKLY REPORTS (MMWR)

According to the Centers for Disease Control and Prevention (CDC) tobacco use remains the leading preventable cause of disease and death in the United States with an estimated 480,000 premature deaths annually, including more than 41,000 deaths resulting from secondhand smoke exposure. These data translate to about one in five deaths related to tobacco use annually, or 1,300 deaths every day. Each year, the United States spends nearly $170 billion on medical care to treat smoking-related disease in adults. From March 2018 through February 2019, the CDC released 13 MMWRs related to tobacco use. These reports provide useful data that researchers, health departments, community organizations and others use to assess and develop ongoing evidence-based programs, policies and interventions to eliminate and/or prevent the economic and social costs of tobacco use.

2018: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2018/index.htm

2019: https://www.cdc.gov/tobacco/data_statistics/mmwrs/byyear/2019/index.htm

Youth Smoking Rates and Trends

According to the June 8, 2018 MMWR, which was an analysis of data from the 2011-2017 National Youth Tobacco Surveys (NYTS), there were substantial increases in electronic cigarette (e-cigarette) and hookah use among high school and middle school students, whereas significant decreases were observed in the use of cigarettes, cigars, smokeless tobacco, pipe tobacco, and bidis. The NYTS is a cross-sectional, voluntary, school-based, pencil-and-paper questionnaire self-administered to US middle and high school students. A three-stage cluster sampling procedure generated a nationally representative sample of US students attending public and private schools in grades 6–12.

Analysis of the 2017 NYTS data demonstrated that e-cigarettes were the most commonly used tobacco product among high school (11.7%; 1.73 million) and middle school (3.3%; 0.39 million) students. E-cigarette use in high school students was followed by cigars (7.7%), cigarettes (7.6%), smokeless tobacco (5.5%), hookah (3.3%), pipe tobacco (0.8%), and bidis (0.7%). E-cigarettes were the most commonly used tobacco product among non-Hispanic white (14.2%) and Hispanic (10.1%) high school students, whereas cigars were the most commonly used tobacco product

among non-Hispanic black (black) high school students (7.8%). Among high school students, current use of any tobacco product decreased from 24.2% (estimated 3.69 million users) in 2011 to 19.6% (2.95 million) in 2017. Among middle school students, current use of any tobacco product decreased from 7.5% (0.87 million) in 2011 to 5.6% (0.67 million) in 2017.

The authors highlight the need for sustained efforts to implement proven tobacco control policies and strategies that are critical to preventing youth use of all tobacco products. There is concern about the rising popularity of e-cigarettes and availability of flavored tobacco products. This concern was amplified by another MMWR publication reporting the prevalence of e-cigarette use among high school students using the 2018 NYTS data. These results were published in November 2018 prior to the publication of the full survey results. E-cigarette use among high-schoolers climbed from 11.7% in 2017 to 20.8% in 2018.

Adult Smoking Rates

According to a study in the November 9, 2018 MMWR, an estimated 14% of US adults (34.3 million) were current cigarette smokers in 2017, representing a 67% decline since 1965. However, in 2017, nearly nine in 10 (41.1 million) adult tobacco product users reported using a combustible tobacco product, with cigarettes being the product most commonly used. To assess recent national estimates of tobacco product use among US adults aged 18 years or older, the CDC, the Food and Drug Administration, and the National Institutes of Health's National Cancer Institute analyzed data from the 2017 National Health Interview Survey (NHIS). The NHIS is an annual, nationally representative in-person survey of the noninstitutionalized US civilian population. The NHIS core questionnaire is administered to a randomly selected adult in the household (the sample adult).

According to the analysis, an estimated 47.4 million US adults (19.3%) currently used any tobacco product, including cigarettes (14.0%; 34.3 million); cigars, cigarillos, or filtered little cigars (3.8%; 9.3 million); electronic cigarettes (e-cigarettes) (2.8%; 6.9 million); smokeless tobacco (2.1%; 5.1 million); and pipes, water pipes, or hookahs (1.0%; 2.6 million). Among current tobacco product users, 19.0% (9.0 million) used 2 or more tobacco products.

Multiple tobacco product users are at increased risk for nicotine addiction and dependence. E-cigarettes were commonly used among multiple tobacco product users. Primary reasons for e-cigarette use among adults include curiosity, flavoring, cost, consideration of others, convenience, and simulation of cigarettes.

TOBACCO CONTROL NEWS

Newest E-cigarette is High in Nicotine and Appealing to Youth

From 2016-2017 Juul sales increased by 641% according to the CDC. The CDC analyzed e-cigarette sales from retail stores in the U.S. during 2013 to 2017. The study assessed the five top-selling manufactures: Japan Tobacco, British American Tobacco, JUUL Laboratories, Altria and Imperial Tobacco, among others. Juul, unlike its e-cigarette competitors, does not look like a cigarette or smoking device. Juul is designed to look like a flash drive which makes it appealing to youth. It is easy to disguise and use discreetly. The popularity of JUUL among youth has helped the product account for 73% of e-cigarette sales in the U.S. and sales of Juul represent one in three e-cigarette sales nationally in retail locations.

In addition to its youth-appealing flavors and sleek design, one Juul cartridge contains the same amount of nicotine as a pack of cigarettes. The company's website claims the product delivers

nicotine up to 2.7 times faster than other e-cigarettes. Many young people are not even aware that they are consuming nicotine when they use e-cigarettes. Results from an April 2018 Truth Initiative® study published in Tobacco Control show that nearly two-thirds of JUUL users between 15 and 24 years old did not know that the product always contains nicotine.

In November 2018 Forbes reported that the FDA was seeking nationwide restrictions on the sales of fruity-flavored nicotine vaping cartridges. Juul, likely aware of the impending FDA crackdown stopped sales of its fruit-flavored nicotine pods in retail stores (though it will continue to sell them online) and has shut down its Facebook and Instagram pages in the U.S.

Underage Smokers find Pharmacies an Easy Source for Cigarettes

A team of researchers led by Joseph Lee, PhD, MPH, East Carolina University, examined the inspections of tobacco sales to minors conducted by the US Food and Drug Administration (FDA) in approximately 13,200 pharmacies from January 2012 to December 2017. The violation rate for tobacco sales to youths in FDA inspections at the top US pharmacies varied by chain and was highest at Walgreens. The findings were published in *JAMA Pediatrics* (Lee JGL, Schleicher NC, Lea EC, et al. US Food and Drug Administration inspection of tobacco sales to minors at top pharmacies, 2012-2017. *JAMA Pediatr*. 2018;172(11):1089-1090. doi:10.1001/jamapediatrics.2018.2150).

In February the FDA initiated enforcement action against Walgreens for underage tobacco sales. Twenty-two percent of Walgreens stores inspected have illegally sold tobacco products to minors, making it the top violator among pharmacies selling tobacco products.

Walgreens is not the only retail pharmacy violating sales to minors but they are the first one that the FDA seeks to bar all tobacco sales for 30 days. Since the FDA began inspecting retail locations in 2010, Walgreens has received more than 1,550 warning letters and 240 civil money penalty actions against its stores nationwide.

According to a research letter published in *JAMA Internal Medicine* (Krumme AA, Choudhry NK, Shrank WH, et al. Cigarette purchases at pharmacies by patients at high risk of smoking-related illness. JAMA Intern Med. 2014;174(12):2031-2032. doi:10.1001/jamainternmed.2014.5307) one in 20 patients who were taking medications for tobacco exacerbated diseases (asthma, COPD and hypertension) purchased cigarettes at a pharmacy.

Tobacco control advocates, public health organizations and medical associations, including the AMA, have called on Walgreens to no longer sell tobacco products. Selling tobacco products in a pharmacy whose primary business is to provide medications to treat and/or prevent diseases while selling products that contribute those diseases sends the wrong message to consumers.

AMA opposes sales of tobacco products in pharmacies and adopted its policy calling for a ban in 2009 and reaffirmed this policy in 2013.

AMA TOBACCO CONTROL ACTIVITIES

AMA Fights for FDA's authority to regulate tobacco products

The AMA joined with other physician groups, including the American Thoracic Society, American Academy of Family Physicians, American College of Cardiology and American College of Physicians, urging Congress to oppose any provisions to weaken or delay FDA's authority to

regulate all tobacco products. An important part of the Family Smoking Prevention and Tobacco Control Act, which Congress enacted with bipartisan support in 2009, was a requirement that new tobacco products undergo a scientific review by FDA. Based on its scientific assessment, FDA can prohibit new tobacco products that are harmful to public health from the marketplace.

According to the co-signed letter, in recent years, the House has included provisions in the Agriculture-FDA appropriations bill to exempt thousands of tobacco products, including many candy- and fruit-flavored products, from FDA's scientific product review.

AMA Supports Efforts to Control Nicotine

The AMA was one of the medical and public health organizations signing on to a joint letter to Dr. Scott Gottlieb, then FDA commissioner, in support of the Agency's initiative to move toward a product standard to reduce the nicotine level in cigarettes to non-addictive or minimally addictive levels. Such a standard would have massive public health benefits. Tobacco use is still the number one preventable cause of death. Nicotine, the addictive ingredient in tobacco products, makes it difficult for many adults to quit and keeps youth smoking.

The AMA and others urged the FDA to go further and include all combustible tobacco products in the nicotine product standard, including those currently on the market and those that may come on the market in the future. Exemption of other combustible products would invite tobacco manufacturers to market existing and develop new non-cigarette substitutes that would lead cigarette smokers to substitute those products, like the small flavored cigars the industry introduced after flavored cigarettes were removed from the market. It also would make the exempted products a potential vehicle for youth initiation. Thus, we urge FDA to make any nicotine reduction product standard applicable to other combustible tobacco products to prevent the industry from circumventing the new rule just as they did after the ban on flavored cigarettes.

AMA Responds to Other Federal Register Notices on FDA Tobacco Regulations

As part of its regulatory authority over cigarettes and other tobacco products, the FDA was soliciting for public comments to assist the agency in implementing initiatives that would reduce the health harms associated with smoking and tobacco use. The AMA, as part of its collaboration with other national medical associations and public health groups, signed on to comments as well as issued its own.

The AMA reiterated its support for the FDA's initiative to create a standard for nicotine in combustible tobacco products but called on the Agency to include *all* tobacco products and create a non-addictive nicotine level standard for all tobacco products, not just cigarettes. Cigarettes are not the only addictive form of tobacco, and applying this standard across all tobacco products is essential to combating the leading cause of preventable death.

The AMA also responded to a Federal Register notice on therapies to reduce youth e-cigarette and other tobacco program use. According to a study in *JAMA Pediatrics* (Watkins LW, Glantz SA, Chaffee BW. Association of noncigarette tobacco product use with future cigarette smoking among youth in the population assessment of tobacco and health (path) study, 2013-2015. JAMA Pediatr. 2018;172(2):181-187. doi:10.1001/jamapediatrics.2017.4173) use of e-cigarettes, hookah, non-cigarette combustible tobacco, or smokeless tobacco by youth is associated with cigarette smoking one year later. This dual use makes it very difficult for youth to quit. The AMA believes that while it is important to consider drug therapies for youth who are already addicted, preventing youth tobacco use and nicotine addiction must be the priority.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-19

Subject: Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws

Presented by: Jerome C. Cohen, MD, Chair

The Council on Constitution and Bylaws has prepared this informational report to help the House of Delegates, prospective candidates for AMA office, and section members understand the role of the Council in developing bylaws that relate to the AMA sections and councils and in serving in an advisory capacity to the Board of Trustees in reviewing changes to council rules and section internal operating procedures.

BACKGROUND

In 2006, the AMA Constitution and Bylaws underwent a significant revision when the Council conducted a comprehensive review of the Bylaws with the goal of modernizing them by eliminating redundant and inaccurate provisions and improving the overall flow and clarity.

Prior to the 2006 revision, one quarter of the Bylaws were devoted to provisions specific to six AMA sections. The Council proposed, and the House agreed, that various procedural provisions pertaining to the councils and the sections should be eliminated from the AMA Bylaws and incorporated into individual council rules or section internal operating procedures to reduce the amount of time and energy spent by the House reviewing procedural details. The Board (rather than the House) was given responsibility to approve future changes in procedures for both the councils and the sections, and the Council on Constitution and Bylaws was tasked with serving as advisory to the Board in reviewing all changes to not overburden the Board with the review process. To facilitate its review, the Council works with the council or section to submit a redlined version of the original rules or internal operating procedures to the Board showing all proposed changes, a transmittal memorandum summarizing the major changes and providing a rationale for those changes, and a final copy that incorporates all changes.

BOARD/COUNCIL ACTIVITY RE: COUNCILS

Seven councils are listed in the AMA Bylaws, which specify each council's responsibilities and membership. Additional details are part of each council's rules, changes to which must be approved by the Board of Trustees and that occasionally require bylaws revisions. The details in the council rules typically includes the council's officers, their election process, and tenure for holding office; the frequency and types of meetings; the keeping of minutes; voting privileges; committees and subcommittees; policy on guests; the quorum for conducting business, and amendments.

When the House of Delegates votes to establish a new section, the Council works collaboratively with the section to develop appropriate bylaw language setting forth its purpose, representation structure, eligibility for section membership and specifying how governing council members are elected. The Council also works closely with the section to develop internal operating procedures

(IOPs), which are approved by the Board of Trustees, and that provide specificity re: composition of the governing council (number of members and their qualifications), procedures for electing governing council members and officers, the term and tenure of those members, filling of vacancies, credential procedures for voting members, meeting details such as resolution submission deadlines, subcommittees, and a quorum for conducting business, both at a governing council level and at the assembly/meeting level.

Subsequent changes to a section's Bylaws are presented to the House for adoption, with changes to a section's IOPs presented through the Council on Constitution and Bylaws to the Board for approval. The Council reviews all proposed changes to ensure that there is no conflict with the AMA Bylaws, and that the IOPs are internally consistent as well as consistent with the IOPs of other sections where applicable.

The councils and the dates of their various rules revisions are:

- Council on Constitution and Bylaws – February 2012, April 2016, April 2019
- Council on Ethical and Judicial Affairs – none to date
- Council on Legislation – April 2017
- Council on Long Range Planning and Development – April 2015
- Council on Medical Education – April 2013
- Council on Medical Service – April 3013
- Council on Science and Public Health – November 2010, April 2013

The Council has also facilitated the Board's review and approval of changes to the standing rules of the AMPAC Board (June 2016) and to the standing rules of the Specialty and Service Society (November 2010, February 2011).

The Council maintains an online database of all council rules to allow one to quickly compare the rules across the councils.

BOARD/COUNCIL ACTIVITY RE: SECTIONS

Since 2006, the number of sections has expanded from 6 to 10. The dates of the various revisions to their IOPs as approved by the Board of Trustees are:

- Academic Physicians Section (formerly the Section on Medical Schools) – September 2008, June 2016
- Integrated Physicians Practice Section (established June 2012) – September 2012, April 2015, April 2016, April 2018
- International Medical Graduates Section – June 2008, June 2010, November 2010, September 2013
- Medical Student Section – February 2009, November 2009, November 2011, April 2015, June 2018
- Minority Affairs Section (established November 2011) – February 2012
- Organized Medical Staff Section – November 2007
- Resident and Fellow Section – November 2009, August 2010, November 2011, April 2016
- Senior Physicians Section (established November 2012) – April 2013, April 2015, November 2018
- Women Physicians Section (established June 2013) – September 2013, September 2017
- Young Physicians Section – March 2007, April 2008, April 2013, November 2016, April 2018

The Council maintains an online database of all Section Internal Operating Procedures to allow one to quickly compare individual IOP provisions across sections, and to search and navigate easily.

The attached appendix describes the elements of an IOP, and documents the review process used by the Council on Constitution and Bylaws and the approval process utilized by the Board of Trustees.

CONCLUSION

The Council on Constitution and Bylaws hopes that this report delineates the role of the Council, the Board of Trustees and the House with respect to the AMA Bylaws, council rules and section Internal Operating Procedures. The Council also believes that the interactive database on Section IOPs can be a useful resource to emerging sections and to established sections alike.

The Council welcomes suggestions for enhancing its interactive databases as well as suggestions for improving the review process.

Appendix: Internal Operating Procedures for the AMA Sections
including CCB and Board Review and Approval, and Implications for Bylaw Amendments

IOP Provisions (includes relevant bylaws)	**Content description**	**CCB[1] (Review for consistency with Bylaws, internal consistency and consistency with other Section IOPs)**	**Board (Review and Approve)[2]**
I. Section Name *7.0.9 Section Status. Sections shall either be fixed or delineated, as determined by the House of Delegates upon recommendation of the Council on Long Range Planning and Development based on criteria adopted by the House of Delegates. A delineated Section must reconfirm its qualifications for continued delineated Section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.*	- Cite bylaw provision that establishes the Section - Identify section's status as delineated or fixed (based on HOD action)	√ Elements are complete and in accordance with adopted HOD action. √ Change in name that requires a bylaw amendment.	√ Review and approve. √ Note that name changes require a Bylaw amendment approved by the HOD.
II. Purposes and Principles *7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:* *7.0.1.1 Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.* *7.0.1.2 Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.*	- Relate to Bylaw 7.0.1 - *May* include additional purposes as are customary or specific to the section or as required by HOD - Section mission (if applicable)	√ Content should relate to Bylaw 7.0.1 and adopted HOD action; √ Purposes not covered in 7.0.1 that may require additional funding or where an additional bylaw may be necessary. √ Per 7.0.3, the programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.	√ Review and approve; determine whether HOD approval also is necessary.

[1] Per Bylaw 6.1.1.4, The Council serves as advisory to the Board of Trustees in reviewing the rules, regulations, and procedures of the AMA Sections.
[2] Per Bylaw 7.0.7, All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees.

IOP Provisions (includes relevant bylaws)	**Content description**	**CCB[1] (Review for consistency with Bylaws, internal consistency and consistency with other Section IOPs)**	**Board (Review and Approve)[2]**
7.0.1.3 Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section. *7.0.1.4 Membership. To promote AMA membership growth.* *7.0.1.5 Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.* *7.0.1.6 Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.*			
III. Membership *Established by HOD and incorporated into Bylaws specific to each Section.*	- Who may join and how - Differentiate between voting and non-voting members - Organizational members - Proportional representation - Provisional members	√ All Section members are AMA members. √ Any provisional membership, non-AMA membership or non-physician membership requires a bylaw change) √ Apportionment/allocation formulas require bylaw amendment	√Review and approve proposed membership criteria. √Note those provisions that require amendment to AMA bylaws.
IV. Officers/Governing Council *7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section.* ***The programs and activities shall be subject to the approval of the Board of Trustees or the House of Delegates.*** *7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section.* *7.0.3.2 Voting. Members of each Section Governing Council shall be elected by the voting members of the Section present at the business meeting of the Section, unless otherwise provided in this Bylaw.*	- Number and specific positions on GC, including ex-officio and nonvoting members. (At minimum, should include chair, vice-chair/chair-elect, delegate and alternate delegate)	√Titles, duties, election, term and tenure of its officers √ If Governing Council is not elected by voting members present at the Section's business meeting (per 7.0.3.2) an "exemptions bylaw" is necessary. √ New positions or changes in officer designations (funding implications). √ Existing bylaw relating to cessation of eligibility for GC members.	Review and approve. Note that some changes to election procedures may be subject to HOD approval for additional bylaws. Note that any Governing Council positions that are not elected require a bylaw.

IOP Provisions (includes relevant bylaws)	**Content description**	**CCB[1] (Review for consistency with Bylaws, internal consistency and consistency with other Section IOPs)**	**Board (Review and Approve)[2]**
IV. Officers/Governing Council (continued) *7.0.3.3 Additional Requirements. Each Section shall adopt rules governing the composition, election, term, and tenure of its Governing Council.* *7.0.4 Officers. Each Section shall select a Chair and Vice Chair or Chair-Elect and other necessary and appropriate officers.* *7.0.4.1 Qualifications. Officers of each Section must be members of the AMA and of the Section.* *7.0.4.2 Voting. Officers of each Section shall be elected by the voting members of the Section, unless otherwise provided in this Bylaw.* *7.0.4.3 Additional Requirements. Each Section shall adopt rules governing the titles, duties, election, term, and tenure of its officers.* *7.0.5 Delegate and Alternate Delegate. Each Section shall elect a Delegate and Alternate Delegate to represent the Section in the House of Delegates.*	- Authority/general statement of GC duties (include statement, "subject to the approval of such programs and activities, when required, by the BOT or HOD") - Eligibility to run for GC -- AMA membership, Section membership, any other relevant criteria - Individual GC member responsibilities - Term/tenure, including overall tenure of GC - Term limits - Vacancies and how filled		
V. Elections *(see Bylaws 7.0.4.2 and 7.0.5 above)*	- Timing of election - Eligibility (including exceptions if relevant) - Nominations—how and when received - Campaign rules - Voter eligibility - Method of voting, including vote counting, how ties are handled and the appeals process (if relevant)	√ Eligibility to run for office, voting eligibility √ Fairness of campaign rules √ Election rules are transparent and clear	Review and approve.

IOP Provisions (includes relevant bylaws)	**Content description**	**CCB[1] (Review for consistency with Bylaws, internal consistency and consistency with other Section IOPs)**	**Board (Review and Approve)[2]**
VI. Standing Committees (if relevant)	- How constituted - Purpose - Duration - Nominations or appointments	√ Criteria is complete and transparent to Section members √ Any additional financial component (additional meetings, etc.)	Review and approve.
VII. Trustee (if relevant) – The HOD must adopt any proposal to add additional designated seats for a trustee	- Eligibility - Term and tenure - Election specifics	√ Consistency with the Bylaws	Review and approve.
VIII. Additional HOD Delegates (beyond 1 allotted per section)	- Regions (if applicable) - Eligibility for election - How elected - Filling of vacancies	√ Consistency with Bylaws that identify the criteria for additional HOD delegates and allocation/apportionment √ Governance √ Regions (if applicable) √ Election rules and procedures	Review and approve. Note that HOD approval is needed for more than 1 delegate to the HOD.
IX. Business Meeting *7.0.6 Business Meeting. There shall be a Business Meeting of members of each Section. The Business Meeting shall be held on a day prior to each Annual and Interim Meeting of the House of Delegates.* *7.0.6.1 Purpose. The purposes of the Business Meeting shall be:* *7.0.6.1.1 To hear such reports as may be appropriate.* *7.0.6.1.2 To consider other business and vote upon such matters as may properly come before the meeting.* *7.0.6.1.3 To adopt resolutions for submission by the Section to the House of Delegates.* *7.0.6.1.4 To hold elections.*	- Date and Location - Call to the Meeting - Representatives to the Meeting, including eligibility criteria for organizational reps - Certification and registration processes - Official observers and guests - Meeting purpose	√ Additional purposes of the Business meeting may require an "exceptions" bylaw √ Verify rules of procedure are comprehensive and include the rights and privileges of Section members, including any limitations on participation or vote.	Review and approve. Additional purposes of the Business meeting may require a bylaw adopted by the HOD.

IOP Provisions (includes relevant bylaws)	**Content description**	**CCB[1] (Review for consistency with Bylaws, internal consistency and consistency with other Section IOPs)**	**Board (Review and Approve)[2]**
IX. Business Meeting (continued) *7.0.6.2 Meeting Procedure.* *7.0.6.2.1 The Business Meeting shall be open to all members of the AMA.* *7.0.6.2.2 Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.* *7.0.6.2.3 The Business Meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.*	- Business--how resolutions are submitted, including timeline and provisions for late or emergency resolutions - Online testimony/comments - Convention Committees: how selected and function - Rules of Order - Quorum		
X. Appointments/Endorsements	- Appointments to AMA or external groups; liaison assignments - Endorsements/nominations of Section members running for AMA elected positions - How selected - Section endorsement of BOT or Council candidates	√ Conflicts with Bylaws √ Transparency of nomination and fair selection processes √ Additional funding requirements	Review and approve
XI. Miscellaneous *7.0.7 Rules. All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees.*	- Parliamentary authority - Internal policies - IOP Amendments	√ Any IOP amendments need a corresponding bylaw?	Review and approve

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-A-19

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: James E. Sabin, MD, Chair

At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a detailed explanation of its judicial function. This undertaking was motivated in part by the considerable attention professionalism has received in many areas of medicine, including the concept of professional self-regulation.

CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove a membership application or to take action against a member. The disciplinary process begins when a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an applicant or member is reported to the AMA. This information most often comes from statements made in the membership application form, a report of disciplinary action taken by state licensing authorities or other membership organizations, or a report of action taken by a government tribunal.

The Council rarely re-examines determinations of liability or sanctions imposed by other entities. However, it also does not impose its own sanctions without first offering a hearing to the physician. CEJA can impose the following sanctions: applicants can be accepted into membership without any condition, placed under monitoring, or placed on probation. They also may be accepted, but be the object of an admonishment, a reprimand, or censure. In some cases, their application can be rejected. Existing members similarly may be placed under monitoring or on probation, and can be admonished, reprimanded or censured. Additionally, their membership may be suspended or they may be expelled. Updated rules for review of membership can be found at https://www.ama-assn.org/governing-rules.

Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities during the most recent reporting period is presented.

APPENDIX

CEJA
Judicial Function
Statistics

APRIL 1, 2018 – MARCH 31, 2019

Physicians Reviewed	SUMMARY OF CEJA ACTIVITIES
1	Determinations of no probable cause
50	Determinations following a plenary hearing
14	Determinations after a finding of probable cause, based only on the written record, after the physician waived their plenary hearing right

Physicians Reviewed	FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS
10	No sanction or other type of action
4	Monitoring
9	Probation
17	Revocation
15	Suspension
4	Censure
4	Reprimand
2	Admonish

Physicians Reviewed	PROBATION/MONITORING STATUS
6	Members placed on Probation/Monitoring during reporting interval
9	Members placed on Probation without reporting to Data Bank
18	Probation/Monitoring concluded satisfactorily during reporting interval
7	Memberships suspended due to non-compliance with the terms of probation
47	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
24	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 5-A-19

Subject: Discrimination Against Physicians by Patients

Presented by: James E. Sabin, MD, Chair

Policy D-65.991 provides that our AMA will study:

1. The prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests;
2. Hospitals' and other health care systems' policies or procedures for handling patient bias; and
3. The legal, ethical, and practical implications of accommodating or refusing such reassignment requests.

The Council on Ethical and Judicial Affairs (CEJA) was asked to develop guidance for physicians in response to this directive.

CEJA's review of relevant literature indicates that patient requests to be treated by a physician of a certain race, ethnicity, religion, sex, or other perceived characteristic may be driven by bias and bigotry, but it may also reflect cultural expectations or constraints, an individual's previous health care experiences, or the historical experiences of patient communities. How physicians and health care organizations should respond can depend significantly on the particular circumstances in which the request is made.

To adequately explore these complex issues, CEJA needs additional time to deliberate before presenting a report to the House of Delegates at the 2019 Interim Meeting.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-A-19

Subject: Amendment to E-2.2.1, "Pediatric Decision Making"

Presented by: James E. Sabin, MD, Chair

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 3-I-18, "Amendment to E-2.2.1, 'Pediatric Decision Making.'" The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

E-2.2.1– Pediatric Decision Making

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

(a) Provide compassionate, humane care to all pediatric patients.

(b) Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

(c) Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.

(d) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.

(e) Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.

(f) When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.

(g) When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.

(h) When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-19

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Alfred Herzog, MD, Chair

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD), with an abbreviated version created in even numbered years by the American Medical Association (AMA) Board of Trustees (BOT), pursuant to AMA Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.

This demographic report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, "Diversity of AMA Delegations," which states that, "Our AMA encourages…state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity..." and AMA Policy G-610.010, "Nominations," which states in part:

> Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity…

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates, alternate delegates, the BOT, and councils, sections and special groups (hereinafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of HOD Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2018 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2018 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the 617 allotted at the 2018 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for slightly over one-fifth of AMA members (20.8%) and the total U.S. physician population (22.3%), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD 2-A-17, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 2-A-17. Changes are not highlighted for the BOT due to the small number of Board members.

- The demographic characteristics of delegates to the HOD remained largely unchanged; the only demographic group among which a change of greater than two percentage points was observed was among White, non-Hispanic delegates, who made up 72.8% of all delegates in 2016, and 70.2% in 2018, a decrease of 2.6 percentage points.
- Among alternate delegates, increases of greater than two percentage points were observed among those age 40-49 (+2.5 percentage points) and among women (+4.8), while the percentage of male alternate delegates decreased by 4.8 percentage points.
- Among CSSG, increased representation was observed among those under age 40 (+3.8) and among females (+8.3), while decreased representation was observed among males (-8.3) and in the 60-69 age group (-5.6).
- Members under age 40 now make up over half of the Association’s membership (51.5%), an increase of 2.3 percentage points over 2016. Additionally, the proportion of White, non-Hispanic AMA members decreased by 3.4 percentage points. However, the percentage of AMA members for whom race/ethnicity information was unavailable increased by 4.0 percentage points.

	Delegates	Alternate Delegates	Board of Trustees[1]	Councils and Leadership of Sections and Special Groups[2]	AMA Members	All Physicians and Medical Students
Count	594[3]	401	20	170	250,253	1,341,682
Mean Age (Years)[4]	56.4	51.1	57.0	50.4	46.0	51.0
Age distribution						
Under Age 40	14.1%	22.7%	10.0%	32.9%↑	51.5%↑	29.7%
40-49 Years	10.4%	18.7%↑	15.0%	11.2%	9.7%	18.5%
50-59 Years	22.2%	23.9%	15.0%	15.3%	9.9%	17.4%
60-69 Years	34.5%	26.2%	55.0%	24.7%↓	10.8%	16.9%
70 or More	18.7%	8.5%	5.0%	15.9%	18.1%	17.5%
Gender						
Male	73.6%	66.8%↓	70.0%	53.5%↓	64.3%	64.8%
Female	26.4%	33.2%↑	30.0%	46.5%↑	35.7%	34.7%
Unknown	0.0%	0.0%	0.0%	0.0%	0.1%	0.5%
Race/ethnicity						
White, Non-Hispanic	70.2%↓	66.6%	70.0%	59.4%	52.7%↓	51.0%
Black, Non-Hispanic	5.1%	4.0%	15.0%	7.1%	4.6%	4.2%
Hispanic	2.9%	4.7%	0.0%	6.5%	5.5%	5.5%
Asian/Asian American	9.1%	13.5%	5.0%	15.3%	14.6%	15.3%
Native American	0.2%	0.0%	0.0%	0.0%	0.3%	0.3%
Other[5]	1.5%	1.0%	0.0%	1.2%	1.4%	1.4%
Unknown	11.1%	10.2%	10.0%	10.6%	20.8%↑	22.3%
Education						
US or Canada	93.3%	90.8%	95.0%	90.0%	82.6%	77.1%
IMG	6.7%	9.2%	5.0%	10.0%	17.4%	22.9%

Table 1. Basic Demographic Characteristics of AMA Leadership

Table 2 displays life stage, present employment and self-designated specialty of AMA leadership.

- Residents, interns and fellows now make up nearly one quarter of all AMA members (24.7%), an increase of 3.0 percentage points over 2016.
- Among delegates, only those employed by medical schools (-2.4) saw a change of two percentage points or greater.
- The percentage of student alternate delegates decreased (-2.4) while the percentage of established alternate delegates increased (+3.8). Changes of two percentage points or greater were also observed among self-employed solo practice (-3.0), student (-2.4), OB/GYN (-2.2) group practice (+3.8) and family medicine (+2.1) alternate delegates.
- Young physician representation among CSSG increased by 5.9 percentage points, while the percentage of established physicians (age 40-64) declined by 3.5 percentage points.

[1] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[2] Numbers do not include non-physicians on the Council on Legislation and AMPAC. In addition, Appendix A contains a listing of the AMA councils, sections, and special groups.
[3] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[4] Age as of December 31. Mean age is the arithmetic average.
↑ Indicates an increase of at least two percentage points compared with 2016.
↓ Indicates a decrease of at least two percentage points compared with 2016.
[5] Includes other self-reported racial and ethnic groups.

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	594	401	20	170	250,253	1,341,682
Life Stage						
Student[1]	5.1%	6.2%↓	5.0%	11.8%	22.5%	8.1%
Resident[1]	5.2%	5.7%	5.0%	11.2%	24.7%↑	10.4%
Young (under 40 or first 8 years in practice)[2]	5.2%	13.7%	5.0%	15.9%↑	7.9%	15.6%↓
Established (40-64)	49.8%	52.4%↑	50.0%	34.1%↓	21.8%	40.5%↑
Senior (65+)[2]	34.7%	21.9%	35.0%	27.1%	23.2%	25.4%
Present Employment						
Self-employed Solo Practice	15.0%	9.7%↓	25.0%	12.4%	7.7%	8.6%
Two Physician Practice	2.2%	2.2%	5.0%	1.2%	1.4%	1.6%
Group Practice	40.4%	39.9%↑	35.0%	27.6%	22.4%	40.6%
Non-Government Hospital	5.1%	5.7%	0.0%	4.1%↓	2.5%	3.1%
State or Local Government Hospital	10.4%	11.5%	10.0%	11.8%	4.2%	6.9%
HMO	0.7%	1.2%	0.0%	0.6%	0.1%	0.2%
Medical School	4.2%↓	5.2%	10.0%	8.8%	1.1%	1.6%
US Government	3.7%	5.0%	0.0%	2.4%	1.1%	1.9%
Locum Tenens	0.2%	0.2%	0.0%	0.0%	0.2%	0.2%
Retired/Inactive	7.2%	4.7%	0.0%	7.1%	11.0%	11.7%
Resident/Intern/Fellow	5.2%	5.7%	5.0%	11.2%	24.7%↑	10.4%
Student	5.1%	6.2%↓	5.0%	11.8%	22.5%	8.1%
Other/Unknown	0.7%	2.5%	5.0%	1.2%	1.1%	5.0%
Self-designated specialty[3]						
Family Medicine	10.6%	11.0%↑	15.0%	6.5%↓	8.5%	11.6%
Internal Medicine	21.2%	20.2%	25.0%	14.7%↓	19.3%	22.9%
Surgery	23.6%	20.4%	15.0%	19.4%	13.6%	13.3%
Pediatrics	4.2%	4.0%	0.0%	7.1%	5.0%	8.7%
OB/GYN	6.6%	4.2%↓	0.0%	9.4%↑	5.0%	4.7%
Radiology	4.9%	5.7%	5.0%	4.7%	3.5%	4.5%
Psychiatry	4.9%	3.5%	5.0%	8.2%	4.0%	5.2%
Anesthesiology	3.5%	3.7%	10.0%	3.5%	3.6%	4.6%
Pathology	2.0%	3.2%	0.0%	0.6%	1.7%	2.2%
Other Specialty	13.5%	17.7%	20.0%	14.1%	13.3%	14.3%
Student	5.1%	6.2%↓	5.0%	11.8%	22.5%	8.1%

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

1 For further data, including information on state medical associations and national medical specialty
2 societies, please see Appendix A.

[1] Students and residents are so categorized without regard to age.
↓ Indicates a decrease of at least two percentage points compared with 2016.
[2] Age delineation reflects section/group definition of its membership.
↑ Indicates an increase of at least two percentage points compared with 2016.
[3] See Appendix B for a listing of specialty classifications.

PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRPD queried state and specialty societies on initiatives they have instituted to encourage diversity, particularly by age, among their delegations, and the outcomes of these initiatives.

In general, associations and societies that have implemented one or more initiatives aimed at increasing diversity have reported some degree of success. Most often, they defined success as leadership demographics more closely aligned with those of the society's membership at large and/or the demographic characteristics of the physician population in the society's geographic area. Other measures of success included decreases in the average age of delegates, greater recruitment of candidates with diverse demographic characteristics to specialties and/or specialty societies, and increased participation and subsequent engagement within societies by early career physicians.

Please note that some initiatives mentioned by respondents were included in CLRPD Reports 3-A-15, "Best Practices and Successful Efforts to Increase Diversity, by Age, of AMA Delegates and Alternate Delegates," and 2-A-17, "Demographic Characteristics of the House of Delegates and AMA Leadership," and not duplicated in this document. Please refer to those reports for further information.

- Task forces: Several societies have instituted task forces on diversity, inclusion and leadership to identify solutions that may be beneficial to their specific society. This may be particularly useful as solutions are not "one-size-fits-all," and initiatives that may be possible for one society may be impossible for another to implement. These task forces considered a variety of elements of diversity, including but not limited to age, race, ethnicity and gender identity. One society reported that the task force resulted in the development of a Minority Affairs Section specific to the society. More than one of these task forces recommended and/or led to the development of minority mentoring programs to encourage minority candidates to consider future leadership roles within their societies and/or encourage minority candidates to consider careers in specific specialties (see below).

- Specific positions for younger physicians and trainees: Many societies mentioned that certain positions within their organizations are set aside for residents/fellows and/or young physicians. Some of these included seats on their societies' boards of trustees, councils, and delegations to the AMA HOD. One society indicated that they aimed to have at least half of their delegation made up of younger physicians and the other half of seasoned mentors. Another society indicated that while positions were not mandated, current leaders were encouraged to identify and reach out to younger colleagues who they believed would be good candidates for leadership roles in the future. Another association makes use of funds donated to its foundation to subsidize students and residents to attend AMA meetings.

- Efforts to recruit women and minority candidates to specialties: Multiple specialty societies indicated that they were currently engaged in initiatives to recruit more female and minority candidates into their specialties, increase the number of underrepresented minorities that apply and are accepted to residency programs, and/or increase interest in their specialties among minority college and medical school students. One society that has implemented such an effort indicated that while no initiative was in place with the specific goal of promoting diversity among society leadership, diversity at annual meetings had increased, and the society has worked to develop ways that trainees and early career members can engage with the organization and its programs.

- Minority mentorship programs: Specific types of initiatives aimed at recruiting diverse candidates to specific specialties mentioned by multiple societies were mentorship programs. These programs attempt to attract minority medical students to careers in specific specialties, and participation in related specialty societies. One society's program provides grants to 20 recipients, focusing in particular on third and fourth year medical students who have indicated strong interest in entering the society's specialty; approximately one in three program participants go on to match in the specialty. This society has also implemented a "Diversity Champion" initiative, which aims to encourage all residency programs within the specialty to appoint a diversity champion, an individual focused on outreach to medical schools, holistic review of residency applicants, expanded cultural competency among residency programs, and other efforts.

- Candidate nominating committees: A number of societies indicated that the use of nominating committees to identify candidates for leadership roles has led to improved diversity among candidates and leaders. Nominating committees are often encouraged to consider the demographic makeup of societies, as well as those of leadership, including boards of trustees, delegations, etc. In addition to demographic characteristics previously listed, other elements of diversity considered by nominating committees included specialty, practice setting and geographic region. Multiple societies indicated that nominating committee members are appointed for a set number of years and selected from varied geographic areas.

CLRPD applauds those associations and societies currently engaged in efforts to increase diversity among their leadership and specialties, while also recognizing that various limitations exist that may make such efforts difficult to implement. The Council hopes, however, that the initiatives above may act as useful examples for those associations and societies considering strategies by which to promote diversity among their own membership and leaders.

APPENDIX A

Table 3. Basic Demographic Characteristics of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees[1]	Councils and Leadership of Sections and Special Groups[2]	AMA Members	All Physicians and Medical Students
Count	594	401	20	170	250,253	1,341,682
Mean Age (Years)[3]	56.4	51.1	57.0	50.4	46.0	51.0
Age distribution						
Under Age 40	84	91	2	56	128,935	399,122
40-49 years	62	75	3	19	24,268	248,239
50-59 years	132	96	3	26	24,709	232,842
60-69 years	205	105	11	42	27,141	226,440
70 or more	111	34	1	27	45,200	235,039
Gender						
Male	437	268	14	91	160,796	868,937
Female	157	133	6	79	89,245	465,592
Unknown	0	0	0	0	212	7,153
Race/ethnicity						
White, Non-Hispanic	417	267	14	101	131,898	684,276
Black, Non-Hispanic	30	16	3	12	11,587	56,495
Hispanic	17	19	0	11	13,809	73,990
Asian/Asian American	54	54	1	26	36,656	204,640
Native American	1	0	0	0	875	3,496
Other[4]	9	4	0	2	3,477	19,266
Unknown	66	41	2	18	51,951	299,519
Education						
US or Canada	554	364	19	153	206,697	1,034,954
IMG	40	37	1	17	43,556	306,728

[1] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[2] Numbers do not include non-physicians on the Council on Legislation and AMPAC.
[3] Age as of December 31. Mean age is the arithmetic average.
[4] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	594	401	20	170	250,253	1,341,682
Life Stage						
Student[1]	30	25	1	20	56,192	109,082
Resident[1]	31	23	1	19	61,928	139,222
Young (under 40 or first 8 years in practice)[2]	31	55	1	27	19,698	209,120
Established (40-64)	296	210	10	58	54,466	544,007
Senior (65+)[2]	206	88	7	46	57,969	340,251
Present Employment						
Self-Employed Solo Practice	89	39	5	21	19,263	115,266
Two Physician Practice	13	9	1	2	3,560	22,050
Group Practice	240	160	7	47	55,933	544,717
Non-Government Hospital	30	23	0	7	6,255	42,014
State or Local Government Hospital	62	46	2	20	10,594	92,236
HMO	4	5	0	1	215	2,243
Medical School	25	21	2	15	2,834	21,563
US Government	22	20	0	4	2,654	25,930
Locum Tenens	1	1	0	0	454	2,696
Retired/Inactive	43	19	0	12	27,542	157,414
Resident/Intern/Fellow	31	23	1	19	61,928	139,222
Student	30	25	1	20	56,192	109,082
Other/Unknown	4	10	1	2	2,829	67,249
Self-designated specialty[3]						
Family Medicine	63	44	3	11	21,350	155,064
Internal Medicine	126	81	5	25	48,229	306,907
Surgery	140	82	3	33	34,119	178,587
Pediatrics	25	16	0	12	12,537	116,785
OB/GYN	39	17	0	16	12,637	62,509
Radiology	29	23	1	8	8,682	59,898
Psychiatry	29	14	1	14	9,903	69,764
Anesthesiology	21	15	2	6	8,892	61,501
Pathology	12	13	0	1	4,377	29,480
Other Specialty	80	71	4	24	33,335	192,105
Student	30	25	1	20	56,192	109,082

[1] Students and residents are so categorized without regard to age.
[2] Age delineation reflects section/group definition of its membership.
[3] See Appendix B for a listing of specialty classifications.

Table 5. Characteristics of Specialty Society Delegations[1]

	Mean Age	% Female	% IMG
AMA Members (n =250,253)	47.0	35.7%	17.4%
Specialty Society Delegates and Alternates (n =416)	55.7	32.2%	5.5%
Family Medicine Delegations (n =25)	56.0	32.0%	0.0%
Internal Medicine Delegations (n =87)	57.7	27.6%	10.3%
Surgery Delegations (n =100)	57.2	16.0%	4.0%
Pediatrics Delegations (n =16)	55.7	62.5%	0.0%
OB/GYN Delegations (n =26)	55.7	61.5%	3.8%
Radiology Delegations (n = 28)	55.9	32.1%	3.6%
Psychiatry Delegations (n =25)	55.2	36.0%	8.0%
Anesthesiology Delegations (n =12)	53.7	50.0%	8.3%
Pathology Delegations (n =18)	53.6	22.2%	0.0%
Other specialty Delegations (n =79)	52.3	40.5%	6.3%

[1] See Appendix B for a listing of specialty classifications.

Table 6. Mean Age of AMA Members and Delegations by State

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Alabama	3,062	47.9	10	54.7
Alaska	352	54.2	2	†
Arizona	4,271	47.5	11	58.4
Arkansas	2,021	45.8	5	59.6
California	22,429	51.3	42	55.8
Colorado	4,096	44.1	10	54.4
Connecticut	3,413	46.6	8	66.8
Delaware	668	58.5	2	†
District of Columbia	1,981	38.4	3	†
Florida	13,489	51.7	26	56.1
Georgia	4,874	49.6	10	63.2
Guam	25	57.2	2	†
Hawaii	1,078	54.1	3	†
Idaho	563	56.5	2	†
Illinois	11,069	49.4	21	59.0
Indiana	4,439	46.7	8	59.4
Iowa	2,151	49.8	5	57.6
Kansas	1,903	53.0	7	67.3
Kentucky	3,228	45.9	8	61.8
Louisiana	4,024	40.6	8	52.9
Maine	1,337	42.3	4	65.8
Maryland	4,414	50.8	10	56.4
Massachusetts	12,321	38.2	22	56.9
Michigan	12,011	44.7	23	56.5
Minnesota	4,393	47.2	8	62.4
Mississippi	2,749	46.2	6	56.2
Missouri	4,846	42.9	8	59.3
Montana	679	48.1	2	†
Nebraska	1,640	43.1	5	50.0
Nevada	1,471	47.6	4	67.8
New Hampshire	877	50.1	2	†
New Jersey	7,074	49.2	15	63.7
New Mexico	1,285	48.7	4	60.8
New York	19,468	46.6	29	58.0
North Carolina	5,181	49.1	9	61.3
North Dakota	762	41.2	2	†
Ohio	10,593	44.6	16	55.3
Oklahoma	3,751	45.2	8	63.1
Oregon	1,902	54.0	4	56.8
Other	743	77.7		
Pennsylvania	13,213	47.4	21	63.5
Puerto Rico	1,399	43.4	4	72.0
Rhode Island	1,018	44.5	3	†
South Carolina	4,572	39.4	10	58.3
South Dakota	963	43.7	2	†

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates
Tennessee	4,744	46.3	9	63.2
Texas	18,002	45.9	34	58.3
Utah	1,668	50.1	3	†
Vermont	416	49.2	2	†
Virgin Islands	37	65.4		
Virginia	7,111	44.3	15	64.1
Washington	3,888	53.7	9	54.9
West Virginia	1,831	42.7	4	67.8
Wisconsin	4,556	46.7	9	58.2
Wyoming	202	60.8	2	†
TOTAL	250,253	48.5	501	59.6

Table 7. Women and International Medical Graduates on State Association Delegations

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,062	10	29.8%	1	11.9%	0
Alaska	352	2	34.4%	1	7.7%	0
Arizona	4,271	11	34.0%	2	16.2%	0
Arkansas	2,021	5	33.6%	1	11.1%	1
California	22,429	42	34.3%	11	16.1%	2
Colorado	4,096	10	38.4%	7	4.9%	0
Connecticut	3,413	8	37.7%	2	17.4%	1
Delaware	668	2	31.3%	2	24.0%	0
District of Columbia	1,981	3	49.5%	0	11.8%	0
Florida	13,489	26	30.8%	4	25.7%	3
Georgia	4,874	10	35.0%	2	16.8%	1
Guam	25	2	32.0%	0	56.0%	1
Hawaii	1,078	3	33.7%	1	11.9%	0
Idaho	563	2	21.1%	1	5.5%	0
Illinois	11,069	21	35.4%	4	22.6%	7
Indiana	4,439	8	32.8%	2	15.4%	2
Iowa	2,151	5	32.1%	1	12.8%	0
Kansas	1,903	7	30.0%	1	14.0%	0
Kentucky	3,228	8	33.0%	0	15.1%	0
Louisiana	4,024	8	38.7%	3	13.8%	1
Maine	1,337	4	43.2%	1	8.0%	0
Maryland	4,414	10	37.6%	5	20.8%	4
Massachusetts	12,321	22	45.4%	4	16.1%	1
Michigan	12,011	23	36.3%	7	23.7%	6
Minnesota	4,393	8	35.0%	3	13.5%	0
Mississippi	2,749	6	31.5%	2	10.1%	1
Missouri	4,846	8	36.9%	1	10.6%	2
Montana	679	2	38.4%	1	4.4%	0
Nebraska	1,640	5	35.4%	1	7.8%	0
Nevada	1,471	4	30.3%	1	16.9%	1
New Hampshire	877	2	34.0%	0	16.2%	0
New Jersey	7,074	15	35.1%	3	29.7%	4
New Mexico	1,285	4	37.6%	0	10.9%	0
New York	19,468	29	37.1%	4	27.2%	4
North Carolina	5,181	9	33.4%	3	12.2%	0
North Dakota	762	2	38.3%	1	17.6%	0
Ohio	10,593	16	36.3%	6	16.5%	1
Oklahoma	3,751	8	32.5%	2	11.3%	1
Oregon	1,902	4	33.4%	1	8.5%	0
Other	743	0	14.7%	0	63.1%	0
Pennsylvania	13,213	21	35.2%	4	17.0%	1
Puerto Rico	1,399	4	40.4%	0	19.8%	2
Rhode Island	1,018	3	40.6%	2	13.9%	0

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Percentage of female AMA Members in State	Number of Female Delegates and Alternate Delegates	Percentage of IMG Members in State	Number of IMG Delegates and Alternate Delegates
South Carolina	4,572	10	39.4%	1	5.8%	0
South Dakota	963	2	34.9%	1	11.5%	0
Tennessee	4,744	9	33.7%	1	9.4%	1
Texas	18,002	34	36.1%	11	16.8%	2
Utah	1,668	3	26.7%	0	5.5%	0
Vermont	416	2	39.4%	0	8.4%	0
Virgin Islands	37	0	29.7%	0	35.1%	0
Virginia	7,111	15	38.2%	4	14.8%	1
Washington	3,888	9	33.8%	3	13.1%	1
West Virginia	1,831	4	33.4%	0	20.2%	0
Wisconsin	4,556	9	34.8%	4	15.8%	1
Wyoming	202	2	24.3%	0	9.4%	0
TOTAL	250,253	501	35.7%	123	17.4%	53

American Medical Association Councils, Sections and Special Groups

COUNCILS

- American Medical Political Action Committee
- Council on Constitution and Bylaws
- Council on Ethical and Judicial Affairs
- Council on Legislation
- Council on Long Range Planning and Development
- Council on Medical Education
- Council on Medical Service
- Council on Science and Public Health

SECTIONS

- Academic Physicians Section
- Integrated Physician Practice Section
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Resident and Fellow Section
- Senior Physicians Section
- Young Physicians Section
- Women Physicians Section

SPECIAL GROUPS

- Advisory Committee on LGBTQ Issues

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT 5 OF THE COUNCIL ON MEDICAL EDUCATION (A-19)
Accelerating Change in Medical Education Consortium Outcomes

EXECUTIVE SUMMARY

Phase one of our American Medical Association's (AMA) Accelerating Change in Medical Education (ACE) five-year initiative, launched in 2013, concluded in fall 2018. This innovative initiative, as described in Council on Medical Education Report 2-I-18,

> *[F]ostered a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and communication of groundbreaking ideas and projects. The AMA awarded grants to an additional 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools are represented in the 32-member consortium, which is delivering revolutionary educational experiences to approximately 19,000 medical students—students who one day will provide care to a potential 33 million patients annually.*

The initiative has been successful in stimulating change at member institutions and propagating innovations nationwide. Students benefitted from training in new topics (such as health systems science) and in the creation of more precise, individualized educational pathways to support broad competency development. Faculty members benefitted from evolving funded educational roles and the opportunity for scholarship and academic advancement. Member medical schools reported enhanced reputations that strengthened recruitment and positioned them for additional external funding. Health systems benefitted from faculty and students trained in quality improvement, patient safety, and systems thinking. ACE collaborations produced 168 academic publications, which to date have been cited over 1,000 times. Over 600 consultations involving 250 institutions served to accelerate innovation across the country and internationally. In short, the ACE initiative fostered a community of innovation in medical education centered around our AMA.

This informational report provides a detailed description of the activities and outcomes of the ACE initiative. Impacts on students, faculty members, member institutions, health systems, the general medical education community, patients, and the reputation of the AMA are described. Future directions to advance our AMA's role as a catalyst for medical education innovation are outlined.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-19

Subject: Accelerating Change in Medical Education Consortium Outcomes

Presented by: Carol Berkowitz, MD, Chair

INTRODUCTION

Launched in 2013 by the American Medical Association (AMA), the Accelerating Change in Medical Education (ACE) initiative established and continues to foster a community of innovation and discovery by supporting the development and scaling of creative undergraduate medical education (UME) models across the country. Grants initially were awarded to eleven U.S. medical schools; funding was extended in 2016 to an additional 21 U.S. schools. The AMA convened these schools to create the ACE Consortium, providing an unprecedented opportunity for cross-institutional partnerships to implement and disseminate groundbreaking ideas.[1,2] Almost one-fifth of all allopathic and osteopathic medical schools in the United States are represented by these 32 grantees. Collectively, these schools are delivering revolutionary educational experiences to approximately 19,000 medical students across the country. Extrapolating the reach of students graduating from these programs, it is estimated that they will provide care to approximately 33 million patients annually.

The initiative has been successful in stimulating change at member institutions and propagating innovations across the United States. Students benefitted from training in new topics (such as health systems science) and in the creation of more precise, individualized educational pathways to support broad competency development. Faculty members benefitted from evolving funded educational roles and the opportunity for scholarship and academic advancement. Member medical schools reported enhanced reputations that strengthened recruitment and positioned them for additional external funding. Health systems benefitted from faculty and students trained in quality improvement, patient safety, and systems thinking. ACE collaborations produced 168 academic publications, which to date have been cited over 1,000 times. Over 600 consultations involving 250 institutions served to accelerate innovation across the country and internationally. In short, the ACE initiative fostered a community of medical education innovation centered around our AMA.

This report reviews the historical context prompting the initiative; structure and processes of the project; outcomes for students, faculty members, member institutions, health systems, the general medical education community, patients, and the reputation of the AMA; and outlines future steps.

OUR AMA'S HISTORICAL EDUCATIONAL MISSION AND LEADERSHIP ROLE IN EDUCATIONAL REFORM

Since its founding in 1847, the AMA has demonstrated a commitment to developing and supporting advancements in medical education, both autonomously and in partnership with others. The AMA's influence includes the Council on Medical Education's contributions to the Flexner Report in 1910 and the formation and sponsorship of organizations such as the Liaison Committee on Medical Education (LCME), Accreditation Council for Graduate Medical Education (ACGME), and Accreditation Council for Continuing Medical Education (ACCME).[3]

In 2005, the AMA launched a multi-year forerunner to the ACE initiative, the Initiative to Transform Medical Education (ITME), which was intended to "Promote excellence in patient care by implementing reform in the medical education and training system across the continuum, from premedical preparation and medical school admission through continuing physician professional development."[4] ITME comprised three phases: identification of existing strengths, gaps, and opportunities for improvement in physician preparation; development of recommendations for change in the system of medical education to address the gaps; and prioritization of needed changes in medical education. In 2006, Innovative Strategies for Transforming the Education of Physicians (ISTEP), a separate initiative (later encompassed by ITME), was launched to develop the evidence base needed to generate decisions leading to reform in physician education.[5-10]

To promote sustained organizational support of these important initiatives, the Council on Medical Education in 2007 recommended that the AMA "continue to recognize the need for transformation of medical education across the continuum...and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role."[11]

In 2012, the AMA announced a new strategic plan, which included accelerating change in medical education as one of three key focus areas, leading to the development of the ACE initiative as it is known today.

CONTEXT OF MEDICAL SCHOOL CURRICULUM REFORM PRIOR TO THE LAUNCH OF ACE

Although medical educators have a strong tradition of continual iterative improvements in programming, these efforts have commonly been focused on enhancing individual courses or isolated programs. The turn of the 21st century, marking nearly 100 years since the Flexner Report, served as a stimulus to contemplate more transformative and large-scale change. A plethora of reports acknowledged that the delivery of health care had evolved significantly with little concomitant adjustment in the overarching medical education process. Calls for bold transformative change emerged from national professional organizations, foundations, and advocacy groups, engaging an international audience in a dynamic discussion.[12-23]

The Carnegie Foundation, for example, supported a qualitative analysis by Irby et al. of multiple institutions embarking upon educational innovations, resulting in the 2010 book *Educating Physicians: A Call for Reform of Medical School and Residency.* Four key themes emerged from this work as systemic needs:

- Standardization of outcomes yet individualization of process;
- Integration of formal learning with clinical experience;
- Fostering habits of inquiry and improvement; and
- Formation of professional identity.

The Carnegie report served as a call to action in the medical education community and acknowledged the need for significant resource investment and leadership for organizational change. At the time, however, best practices could not be offered based upon the timing and scope of the team's analysis.[19,20]

In 2010, Susan E. Skochelak, MD, MPH, then Vice President for Medical Education at the AMA, performed a comprehensive review of recommendations for change from the prior decade, with an in-depth analysis of 15 major reports from the United States and Canada (including the AMA's ITME and ISTEP initiatives). Eight major recurring themes were identified:

- Enhancing integration across the educational continuum;
- The need for evaluation and research of educational methods and processes;
- New methods of financing medical education;
- The importance of physician leadership;
- An emphasis on social accountability;
- The use of new technology in education and medical practice;
- Alignment of the educational process with changes in health care delivery; and
- Future directions in the health care workforce.

In discussing the remarkable congruence across such reports, Dr. Skochelak challenged educators to move from research to action: "We can be assured that we don't need to keep asking 'What should we do?' but rather 'How can we get there?'"[12]

Additional scholarly work from this period elaborated upon specific recommendations. The 2010 Lancet Commission report called for tighter integration of medical education systems with health care delivery systems and anchoring desired educational outcomes to evolving societal needs.[17] To meet current social needs, Berwick and Finkelstein advocated that students must be prepared to work in, and contribute to the continual improvement of, health care systems: "Physicians should not be mere participants in, much less victims of, such systems. Instead, they ought to be prepared to help lead those systems toward ever-higher-quality care for all."[21] Addressing the movement toward competency-based approaches (standardized outcomes), Hodges validated the importance and challenges of authentic workplace-based assessment of performance and the merits of individualized pathways, yet cautioned that the professional identity formation of learners not be neglected in shifting paradigms: "There could be no more 'see one, do one, teach one.' Rather the phrase would have to be updated to something like 'watch until you are ready to try, then practice in simulation until you are ready to perform with real patients, then perform repeatedly under supervision until you are ready to practice independently'."[22] Nora addressed the critical need for health systems and academic centers to invest in faculty development: "Faculty members must be given the release-time and the tools necessary for success, with the understanding that they must use these resources appropriately and meet the expectations of their roles."[23]

Despite these repeated calls for change and relatively strong agreement on key elements to be addressed, only marginal progress was made in transforming medical education. Recognizing that significant change may lie beyond the scope of individual institutions, the AMA stepped in to serve as a guiding body to build consensus, identify best practices, and provide both financial and moral support for the challenging work to be done. By committing significant financial resources to this initiative, the AMA generated a sense of urgency among medical educators and administrators.

ACE OBJECTIVES AND PROCESS

Based upon the previously outlined international medical education discourse, the following core objectives were established for ACE:

Objective 1: Developing new methods for teaching and/or assessing key competencies for medical students and fostering methods to create more flexible, individualized learning plans.

Objective 2: Promoting exemplary methods to achieve patient safety, performance improvement, and patient-centered team-based care.

Objective 3: Improving medical students' understanding of the health care system and health care financing.

Objective 4: Optimizing the learning environment.

With objective 1, the AMA endorsed competency-based medical education (CBME), which explicitly aligns curricular offerings and assessment of student performance with the desired outcomes of the educational program. Since CBME has been embraced in graduate medical education (GME), supporting its implementation in UME would promote alignment across the continuum of training. Competency-based approaches enhance attention to areas of performance beyond the traditional focus on medical knowledge and clinical skills. Because each student possesses differing strengths and educational needs, fully fostering this breadth of competency requires flexible, individualized pathways.[23]

Objectives 2 and 3 were quickly identified by the consortium's membership as closely related. Collaboration among the ACE institutions ultimately resulted in articulation of the larger construct of health systems science, identified as the "third pillar" of medical education alongside the traditional focus on basic science and clinical skills. Objectives 2 and 3 are jointly referred to as "health systems science (HSS)" in subsequent sections of this report.[24-26]

Objective 4 acknowledged our AMA's concerns regarding physician burnout. Additional drivers supporting attention to the environment in which students learn include cognitive science about the learning process; a desire to promote the success of a diversity of students; and emerging evidence of "imprinting," or persistence throughout a physician's later career, of certain dimensions of the health system(s) in which one trains (such as quality, cost, and professionalism behaviors).

The ACE program was planned to function at two levels. Grants were awarded to individual institutions to complete local projects aligned with one or more of the initiative's objectives. Additionally, the program was structured to promote organic collaboration among institutions, resulting in amplification and acceleration of the change process.

The AMA's initial request for proposals in 2013 generated an overwhelming response: 119 letters of intent were received, representing 80% of eligible U.S. medical schools. Of those letters of intent, 31 applicants were invited to submit full proposals. To assure attainment of the objectives, successful applicants were required to describe a significant commitment from the relevant associated clinical system. Of the 31 applicants, 11 institutions were selected, each funded at $1 million over a five-year period (see Appendix A, Table A-1). In addition to this funding, the AMA supported two face-to-face meetings of consortium members each year of the grant. Common themes quickly emerged and resulted in collaboration across institutions. Multiple interest groups were established, for which ACE staff provided administrative support and project management, and the AMA convened in-person thematic meetings to propel key shared initiatives. Throughout the process, national partners were engaged to facilitate innovation, including the Association of American Medical Colleges (AAMC), LCME, ACGME, National Board of Medical Examiners (NBME), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and the Josiah Macy Jr. Foundation. Many of the outcomes reported here were generated by such inter-organizational efforts.

In 2015, the AMA recognized the opportunity to further propagate the work undertaken by the first cohort of ACE grantees and to address gaps in existing programs. New partners were solicited under a revised request for proposals, offering more modest funding, and the opportunity was expanded to osteopathic as well as allopathic medical schools. Of 108 applications, twenty-one additional schools were funded at $75,000 over a three-year commitment. (see Appendix A, Table A-1).[1]

At the time of the writing of this report, all Phase 1 grant commitments have been successfully completed. While the consortium continues to operate under a new structure, described later, the remainder of this report focuses on the outcomes of the ACE Consortium's initial five-year phase.

OUTPUTS OF ACE

The ACE member institutions from both funding cohorts implemented significant programs at their sites. Additionally, collaborative efforts among sites served to accelerate and amplify productivity. This section provides an overview of outputs and the major activities that were undertaken in the initiative; the impacts of those changes are described in the following section.

Institutional Outputs

Site-based Projects

Each funded institution implemented site-specific projects aligned with local needs and capacity. Schools defined key objectives for their projects and submitted two progress reports per year. School-based initiatives contributed to the shared ACE objectives of fostering competency-based approaches and individualized pathways, promoting education in HSS, and improving the learning environment. The scope of the projects ranged from a targeted intervention to support a specific theme (such as training in HSS) to sweeping curricular overhauls that addressed multiple objectives. As anticipated, some sites revised their objectives over the life of the grant. Despite these recalibrations, core themes persisted. See Appendix A, Table A-1 for a brief description of each school's project and its relationship to the overarching ACE objectives.

Common Changes to Curricular Content and Structure

Each institution was queried regarding the implementation of curricular content areas of interest to the AMA. Topics that generally moved from contemplation to implementation included elements of HSS (related to objectives 2 and 3); systems thinking; leadership and change agency; clinical informatics and health information technology; value-based care; health care economics; quality improvement; patient safety; teamwork and interprofessional care; and health care policy.

A similar query was made regarding changes in structural frameworks supporting student education. Common programmatic changes supported competency-based medical education (objective 1), including flexible individualized learning plans and deliberate assessment of readiness for internship, as well as optimization of the learning environment (objective 4), including medical student coaching and medical student wellness programs.

See Appendix B, Tables B-1 and B-2 for more detailed information regarding common shifts in curricular content and structure in local institutional projects.

Collaborative Outputs

A significant benefit of convening consortium members twice per year was the sense of community that quickly developed. Institutions striving to implement bold ideas were able to share their strategies and, importantly, share their struggles and failures (an uncommon practice in traditional academic environments). This resulted in a deep, shared commitment to the difficult work of creating the medical schools of the future and spurred rapid dissemination of solutions among consortium members and the academic community.

Table 1, below, presents areas of shared efforts across consortium members. Appendix C provides a more detailed description of these topics.

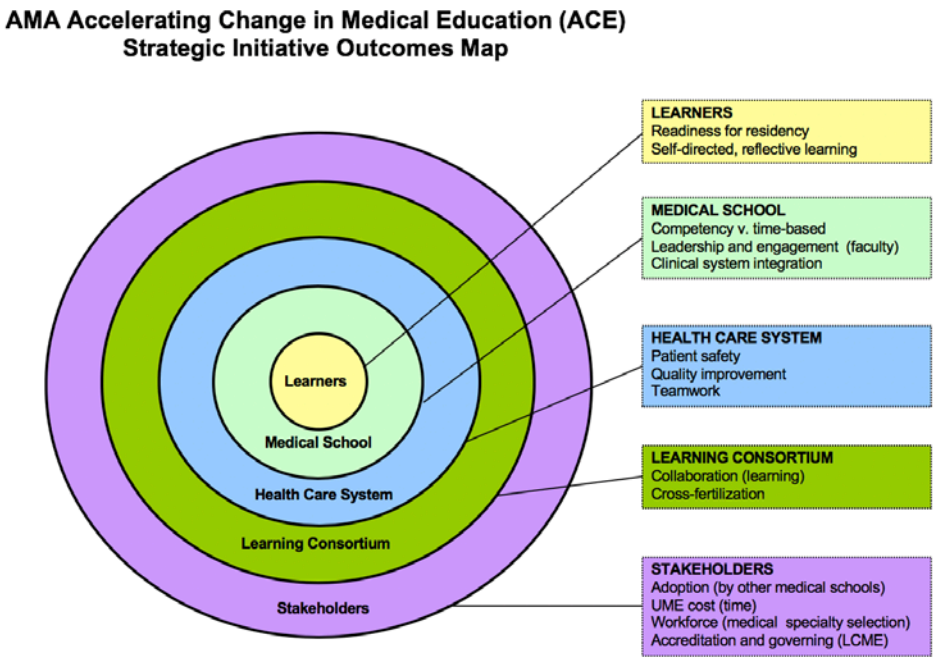
Table 1

Topic Area	Corresponding ACE Objective(s)	Shared Curricular Efforts
Competency-Based Medical Education and Individualized Pathways	Objective 1: Developing new methods for teaching and/or assessing key competencies for medical students and fostering methods to create more flexible, individualized learning plans.	Competency assessments Readiness for residency Individualized learning plans Flexible curricula
Health Systems Science	Objective 2: Promoting exemplary methods to achieve patient safety, performance improvement, and patient-centered team-based care. Objective 3: Improving medical students' understanding of the health care system and health care financing.	Value-added roles for medical students Medical students embedded in the community Patient safety and quality improvement Social determinants of health Chronic disease
Optimizing the Learning Environment	Objective 4: Optimizing the learning environment.	Well-being Master adaptive learner[28] Coaching Technology Evaluation

IMPACT OF ACE

At the formative stage of the consortium, several tiers of potential impact were envisioned, as described in Figure 1. Multiple measures tracked over the life of the initiative reflect the successful implementation of bold innovations across the 32 medical schools, and document the significant impact on member institutions, their constituents, and stakeholders beyond the consortium.

Figure 1



Impact on ACE Learners

Students at consortium schools benefited from direct interventions that included the addition of specific content (such as HSS)[24-26] as well as processes to enhance learning outcomes (such as competency-based approaches and coaching).[23,28]

Grantees reported anticipated enhanced student readiness for residency and anticipated improvements in graduates' competency in patient-centered care, communication, interprofessional collaboration, patient safety, quality improvement, value-based health care, addressing social determinants of health, telemedicine, and electronic health records. Many sites applied ACGME milestones[29] and AAMC Core Entrustable Professional Activities (EPAs)[30] to measure student progress, and the NBME HSS exam provides evidence of the acquisition of new knowledge in these areas.[31] At the time of this report, most member institutions were just starting to graduate cohorts of students affected by changes in programming. Downstream evidence to assess the actual performance of ACE graduates will include graduate surveys, program director surveys, and analyses of ACGME milestone outcomes during residency.

The consortium contributed to a culture change within institutions and the creation of processes to support more precise education. Greater attention to assessment in the workplace generated more timely, actionable feedback for students. Individualized, student-centered, and in some cases accelerated pathways provided greater alignment of learning experiences to learning needs and opportunities for reduced time in school, reduced tuition expenses, and reduced need to repeat material for which the learner is already demonstrably competent.

Professional identity formation was enhanced by many of the grant interventions. Consortium school faculty and students reported that real-life simulations, coaches (as opposed to traditional advisers), and population-centered care frameworks taught students how to care for individual patients and collaborate across specializations to improve health care systems. As one medical student from A.T. Still University-School of Osteopathic Medicine in Arizona offered:

> *As a former student who was permitted to participate in several community health projects while in medical school, I can report on the tremendous impact it has had on my appreciation of community health. Medicine is quite sterile in academia, which is very difficult to escape - even during highly structured clinical years. However, community-based projects seem to breathe life into our profession, allowing us as students to more fully appreciate elements such as specific socioeconomic factors that keep people from pursuing care, or how HIV is experienced in rurality. As a family medicine resident, it is striking how many students seem to find their "purpose" in medicine after a community project inspired some shift in career paths altogether. The common denominator is that deeper connection to a community, which is just so hard to get with the abbreviated time we have in traditional medical school curricula.*

Students also benefitted from participation in leadership and scholarship consortium projects, participating as active partners in designing and refining curricular interventions at many institutions.[32] As seen in Appendix D, novel and disruptive educational methods, such as near-peer mentoring among students, contributed to learning and facilitated successful curricular transition. Students were exposed to various presentation and publication opportunities and, as active leads and co-leads of experience-based scholarship, developed problem-solving skills and adaptability through innovation and creativity.

Impact on ACE Medical Schools

Participating institutions experienced an overarching impact beyond the direct effect of the grant projects. In their final reports to the AMA, grantees were asked to reflect on what had been the most significant contribution of the grant at their institution. The responses were broad, ranging from improvement in specific areas of curriculum (such as interprofessional care and electronic health records) to impacts on institutional culture and prestige.

The magnitude of change that ACE projects demanded involved multiple institutional challenges, including confronting established approaches to education and skepticism about the need for change; senior decision-makers who were resistant to innovation and/or changing the educational status quo; significant in-kind resources needed to implement and sustain changes (including resources to support administrative burden, the need for feasible and motivating compensation models, and new technological platforms); policies, both state and institutional, that did not immediately permit innovation; and the need to develop mechanisms to provide effective and sufficient communication to all stakeholders.

Several schools noted that the prestige of the grant and the consortium provided credibility for their educational mission, which facilitated successful implementation of their grant project and led to changes in their institution's fundamental approach to education. Grant funding and consortium participation stimulated increased collaboration among institutional stakeholders, including students, faculty, and the affiliated health system. Additionally, the grant conferred external validation on institutions as leaders in educational innovation. A sampling of schools' feedback on the initiative provides a glimpse into these opinions:

> *For the AMA to fund our initiatives was confirming, accelerating, consolidating, the push that we needed.*
> Vanderbilt University School of Medicine

> *The ongoing recognition and attention of the project accomplishments continues to facilitate visibility and the sense of culture change.*
> East Carolina Brody School of Medicine

The grant provided important validation of our vision.
University of California, San Francisco School of Medicine

For some schools, the AMA grant spurred additional funding. Schools received supplemental funding for their projects from universities, regional foundations, states, and health systems. Consortium schools received over $16 million in Health Resources and Services Administration grants related to ACE projects, and two schools received gifts related to medical student education totaling $700 million. In addition, ACE schools received grants from the Kern Institute, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, Substance Abuse and Mental Health Services Administration, ACGME, and the National Institutes of Health.

Impact on ACE Faculty

ACE grants prompted significant changes in faculty roles and expertise. Grantees reported that curricular innovations resulted in the creation of new positions or the repurposing of existing positions. Across the 32 schools, 900 faculty positions were affected, and a total of 87 full-time equivalent (FTE) positions were redistributed as novel educational formats drove new faculty roles. The most common new roles included small group facilitators, coaches, and faculty trained to teach HSS and mentor student-led quality improvement projects.[33] These transformative impacts on funded faculty roles are projected to continue even now that AMA grant funds have ceased to support site-based projects.

Faculty challenges related to the change process included faculty and other health professionals' engagement; buy-in for new collaborations; time demands of design and implementation; building and maintaining a team of educators to resolve necessary changes in staffing and facilities; a lag between implementation of novel teaching or assessment methods and faculty comfort with leading them (an unavoidable gap in depth and breadth of expertise); funding for, and leadership of, sustainable faculty training and development; turnover of dedicated faculty or administrators; and providing effective and sufficient communication across all stakeholders.

Despite these challenges, grantees reported that faculty increased their own knowledge areas and expertise. New curricular content areas, such as patient safety and quality improvement, demanded faculty training, which in turn was reported to affect faculty members' own clinical practices. Changes in process also required faculty development. Competency-based methods encouraged faculty members to focus on student development rather than grades, reminding faculty of their critical role in serving the needs of future patients.[34,35] Faculty learned how to develop data-driven curricula and teaching in support of diverse patient care and reported a greater shared sense of purpose across departments and professions. Looking to the future, institutions anticipate expanded faculty knowledge and mentoring, increasing the value that students bring to patients and communities through multiple pathways (e.g., direct patient care and interprofessional teamwork).

Additional faculty impacts included enhanced opportunities for academic advancement. Schools reported that consortium activities stimulated scholarship that would not have occurred otherwise, as well as cross-institutional and cross osteopathic/allopathic collaborations. The resulting manuscripts[24,28,31,33,36-50] were more competitive for publication, improving a key metric for faculty advancement. Sites cited an increase in faculty participation in national and international presentations over the course of the grant, and reported that grant activities led to a total of 71 promotions (reported by 31 of 32 schools) and 99 appointments to named positions within their institution (reported by 29 of 32 schools). Additionally, schools shared that the national prestige associated with consortium membership allowed them to cast a wider net in recruiting top faculty

and administrators to their institutions. Further examples regarding the benefits to faculty of consortium participation may be seen in Appendix E.

Impact on ACE-affiliated Health Care Systems

The most direct impact of consortium activities on affiliated health systems resulted from the deliberate incorporation of HSS training, focusing on how health care is delivered, how health care professionals work together to deliver that care, and how health systems can improve patient care and health care delivery. Some schools designed experiences for students to learn leadership, work in their community, or team up with interprofessional colleagues; others implemented rigorous quality improvement and patient safety training.[51-60] For example, the University of California San Francisco Health System and School of Medicine partnered in 2016 to embed 80 first-year medical student teams as active participants in health systems improvement efforts to address problems aligned with the health system's True North pillars of quality, safety, and value. Meanwhile, at the Pennsylvania State University School of Medicine, students were trained to serve as patient navigators who guide patients through a complex health care continuum.

To capture the impact of such student roles and student-led projects, the AMA launched the Health Systems Science Student Impact Competition in 2018. Forty-six students submitted descriptions of their work. Eligible projects addressed one of the HSS domains, such as leadership, patient safety, quality improvement, or population health. The winning entry was submitted by Kevin Tyan, a student at Harvard Medical School, who implemented strategies to protect patients and health workers from the Ebola epidemic and health care-associated infections. The second-place winner was Richard Lang, a student from Rutgers Robert Wood Johnson Medical School, a student-veteran who drew upon his military experience to improve teamwork training in medical education. The third-place submission was from Jasmyne Jackson, a student at the University of Michigan Medical School who developed a tiered mentorship program to address diversity pipeline issues, engaging pre-medical and medical students who are underrepresented in medicine to promote professional development and empowerment.

Other ACE objectives affected health systems in indirect ways. Competency-based efforts at many schools were designed to better align student training with the needs of patients and populations. The deliberate preparation of students for their responsibilities as interns was a focus at many sites, which is projected to improve the function of the health care system at the time of transition. Similarly, changes to the student learning environment impact all members of the clinical team, including residents, faculty, nurses, and other professionals.[1] Encouraging a system in which all learners work and all workers learn supports an ethos of shared learning and improvement that may mitigate emotional exhaustion and depersonalization.[61]

The ACE application process was structured to require that schools collaborate closely with their health care system, creating a shared understanding of roles, values, and learning needs of participating students. Health system leaders were included in curricula, especially surrounding the development of HSS experiences. For example, Pennsylvania State University College of Medicine notes that:

> *Collaboration with our health system on educational initiatives over the life of the grant includes the following health systems leaders and professionals who have contributed to the design and implementation of the HSS curriculum (UME, GME, faculty development): dean and CEO of the College of Medicine and Health System, vice dean for educational affairs, chief financial officer, chief operating officer, vice president and chief quality officer, vice president of operational excellence, vice president of population health, director of ambulatory*

nursing, chief information officer, clinical and basic science faculty, advanced care practitioners, nurse educators, allied health professionals, social workers, librarians.

Impact on the ACE Learning Consortium: Fostering a Community of Innovation

During the lifespan of the grant, relationships naturally spread across disciplinary lines in the consortium into a collegial, snowballing network spanning multiple topics, purposes, and depths. Although very difficult to quantify, consortium schools reported valuing this outcome tremendously and anticipated the continuation of these relationships into the future.

When asked to note the most significant contribution of the consortium, grantees repeatedly cited interaction with other educators and learning from innovations at other sites. Recurrent themes are well articulated by the following excerpts:

The ACE Consortium serves as a catalyst for innovation. Through conferences, online discussions, and incubator projects, it unifies a variety of experienced American medical school innovators. Through this process, members gain a shared mental model, learn best practices, discuss complex issues in learning communities, and reference a common evidence base.
Faculty, Brody School of Medicine at East Carolina University

The consortium has provided us the opportunity to share ideas, ask for help and have the status/gravitas as a consortium member to implement innovations. Our collaborations have led to deeper understandings of how to educate well and deeply and have caused us to continue to question and reform what we do. We also continue to develop ways to enact our vision of having students be value-added members of the patient care team and have seen the fruits of our past labor with our students' successful entry into their clerkships.
Faculty, CUNY School of Medicine

This consortium reinforces the truth that we are all responsible for the future of health care and that we are teammates, not competitors.
Faculty, A.T. Still University-School of Osteopathic Medicine in Arizona

The single greatest contribution of the consortium may not have been anticipated but was fully realized because of the openness that the AMA demonstrated to ensuring the 'whole was greater than the sum of our parts'. In other words, the Innovation Ecosystem that resulted from the work together in the consortium was the single greatest benefit we realized from our participation in this grant program.
Faculty, University of Michigan Medical School

In just five years, the consortium has become the home of medical education in the United States.
Faculty, New York University School of Medicine

Grantees also credited the following with facilitating the accomplishment of grant project objectives: endorsement by the AMA through the national consortium; internal and external networking that resulted in strong partnerships; consortium membership as a place to seed ideas, learn new approaches to similar problems, and receive professional validation; and financial support, including that from the AMA for travel and consortium meetings.

Consortium grants also led to the creation of environments supportive of student engagement with and partnership in scholarly endeavors. Student debriefings about interventions served as valuable and powerful ways to impact future faculty development. Students expressed their appreciation for being included in this community:

> *As a first-year medical student, I had the opportunity to attend the AMA consortium annual conference. It was here that I was first introduced to the community of medical educators. This community represented a shift in my medical school journey to one being centered about medical education. It was also the place where I found inspiration, learned the power of collaboration between institutions, and was encouraged to pursue my own contributions to the field. However, the most important of the community was the people I had the opportunity to meet. They will serve as role models to me as I continue my career in academic medicine.*
> Medical Student, University of Michigan Medical School

> *I was excited to see such a broad group of medical education professionals exploring ways to shake the status quo of traditional medical curricula through engagement with student perspectives and new technologies. The consortium offers an opportunity for rapid and sustainable change of long-held but flawed standards that currently prevent students from reaching their highest learning potential.*
> Medical Student, Warren Alpert Medical School of Brown University

Impact on the broader medical education landscape: scholarship and dissemination

Scholarship related to ACE educational innovations has been an important vehicle for dissemination. Over the five-year grant period, consortium members authored 168 publications, which to date have been cited by over 1,000 subsequent manuscripts. Ninety-two of these publications related to HSS, and 30 related to competency assessment. Fifty-three papers were published in *Academic Medicine*. Over 270 abstracts have been presented by consortium members in regional, national, and international venues.

The collaborative interest groups of the consortium generated significant dissemination of scholarship in non-traditional ways. The most productive interest group concentrated on defining the domains of HSS, advocating for its status as the third pillar of medical education complementing basic science and clinical skills.[24-25] This group adopted multiple modalities to promote the teaching and assessment of HSS. The resulting textbook[26] has sold over 4,000 copies internationally, and online modules are scheduled to be released in 2019. Additionally, HSS subject matter experts collaborated with the NBME to create a subject examination in HSS[31] to be administered by medical schools. In a January 2019 editorial, *Academic Medicine* Editor-in-Chief David Sklar, MD, reinforced the value of teaching HSS as the third pillar of medical education and cited HSS curricula as a potential marker of school excellence.[62] Another ACE collaborative group focused on medical student coaching created a handbook that has been downloaded more than 7,000 times from the AMA website.[27] A monograph self-published by the AMA outlining the impact of scholarship generated by consortium activities has been downloaded nearly 9,000 times.[63]

Furthering scholarly impact, grantees also served as consultants to other institutions embarking on change processes. As stated previously, the consortium served as a safe space for educators to articulate the many challenges associated with educational innovation, including negotiating accrediting requirements that do not readily allow for innovation; modernizing inflexible educational technologies; forging new collaborations across the health system; managing competing demands on student attention which may detract from the benefits of innovations;

addressing students' concerns that systems thinking may lie beyond their stage of development; coping with challenges of scheduling innovative experiences within required traditional medical education cycles; building effective and sufficient communication; sustaining interventions as students from innovative undergraduate programs transition to GME; measuring educational outcomes and creating evaluation and assessment plans; and handling the complexity of linking educational interventions to patient outcomes.

The strategies that emerged from individual institutions and from consortium activities were of value to schools outside the consortium seeking to innovate. Consultations served to amplify the impact of the ACE initiative into the broader educational community, thus accelerating widespread change. Consortium members reported advising other institutions to use validated tools whenever possible; consider implementing models that already exist rather than creating new ones; increase collaborations with other departments early on in the change process; plan ahead to gather meaningful outcomes data; and ensure that there are supportive systems, processes, and administration in place before committing to such an undertaking. Over the course of the grant, collaborations of ACE schools with one another and with non-consortium institutions exceeded 600 interactions involving over 250 institutions and organizations, reflecting the sense of authority afforded to ACE members in the medical education community.

Member institutions have cooperated with accrediting agencies and governing bodies to enable innovation by removing regulatory and legal barriers. The University of California, Davis, School of Medicine worked with the state legislature of California to alter the required minimum time of training so that students committed to primary care could complete a three-year track aimed at enhancing diversity of the physician workforce. Other interventions promise a potential to reduce the costs of UME: for example, via its competency-based assessment process, Oregon Health & Science University (OHSU) School of Medicine was able to graduate 25 percent of its students a semester early, resulting in an average tuition cost reduction of $17,000. Dialogue in consortium sessions amplified national concerns about scoring for the USMLE, prompting the NBME, in collaboration with the AMA and other influential organizations, to host discussions with subject matter experts to explore this issue more deeply.

Impact on the AMA

Despite the AMA's longstanding investment in medical education, the launch of the ACE initiative represented a bold step into the UME sphere. The investment of significant resources gained initial attention, and the subsequent successful efforts of the consortium have anchored the AMA as a hub for innovation in medical education. As a consortium member school put it, "In just five years, the consortium has become the home of medical education innovation in the United States" (New York University).

In a qualitative study conducted in 2015 by consulting firm Penn Schoen Berland, 31 medical school deans who were not members of ACE were interviewed to solicit their perspectives on educational innovation and the AMA's ability to lead in that space. For several, the ACE initiative changed their view of the AMA: "It's unexpected coming from a trade organization that the AMA has been in the past. It really speaks to the present—the AMA has a different vision, which I am delighted about. I think it's very exciting."

The ACE initiative garnered significant external attention for the AMA, and it is interesting to track how earned media coverage has evolved since the ACE initiative launch in 2013. Initially, ACE coverage mainly appeared in trade publications; this is not unusual for a new initiative, as reporters often prefer to cover results and concrete milestones. ACE's visibility and reach have

grown over the past five years, however, as evidenced by media coverage in national mainstream publications, including the *Wall Street Journal*,[64] National Public Radio,[65] and the *New York Times*.[66] Mentions of ACE work in more prominent, high-impact publications also have grown over time and are often synched to major announcements, such as the launch of the HSS textbook and the electronic health record (EHR) designed for educational settings. The additional uptick in the quality of journal placements was also the result of exposure to consortium meetings, relentless media team pitching, and access to press conference calls with James Madara, MD, Executive Vice President and CEO of the AMA, and Dr. Skochelak. Finally, in 2018, impressions were derived from a significant push to earn attention for the first graduating classes from consortium schools and the five-year anniversary of ACE. Increasingly, the storyline around ACE and the need for reimagining medical education have moved from health trade publications into the public consciousness. See Appendix F, Table F-1 for a listing of top *AMA Wire* articles about ACE.

To capitalize on the interest in ACE activities and expand our reach beyond consortium members, the medical education unit launched a new national conference, ChangeMedEd®, which welcomes both consortium and non-consortium members and medical education stakeholders. The inaugural 2015 conference attracted 273 participants (226 of whom were non-members); attendance rose to 363 in 2017 (including 265 non-members). Additionally, digital platforms have been exploited to create other interactions and stretch engagement to an international scale. Webinars and asynchronous discussions have been offered, with 1,000 participants across seven webinars and over 2,000 participants across 17 asynchronous discussions. More details about virtual-session topics and participation in the webinars are provided in Appendix F, Tables F-2 and F-3.

Other critical AMA initiatives have benefited from direct access to the medical educators and UME curricula affiliated with the ACE Consortium. For example, collaboration with ACE member institutions propelled efforts of the AMA's Improving Health Outcomes unit to address chronic disease by piloting a new structure of the patient history and physical to target the needs of patients with chronic illness.[49] Similarly, synergy exists between the goals of the AMA's Professional Satisfaction & Practice Sustainability unit and ACE efforts to empower students to attack the dysfunction in the health care system by training them in HSS.[61] Such empowerment is expected to enhance a sense of control and well-being, supplementing education's recent focus on individual resilience and wellness.

The myriad activities that comprise the ACE initiative have secured the AMA's position as the leading home for purposeful innovation in medical education.

Impact on patients

The ultimate goal of the ACE initiative is to improve patient care. The impacts of the ACE objectives on learners, faculty members, medical schools, health systems, and the broader medical education community outlined in this report culminate in physicians who are better trained, more satisfied, and poised to shape the constantly evolving health care system—in short, as the AMA mission states, "to promote the art and science of medicine and the betterment of public health."

FUTURE STEPS

The ACE initiative has taken great strides toward creating the medical school of the future. Institutional members of the consortium have offered case studies in accomplishing a variety of needed reforms, and collaborative efforts across sites have identified techniques that can be generalized to other schools. Significantly, all 32 participating schools have committed to continue as members of the consortium despite the cessation of direct funds to support site-based initiatives.

AMA ACE staff will continue to convert developing ideas into tangible products that can be adopted broadly. Ongoing smaller innovation grants and targeted memberships in the consortium will be offered to promote strategic areas of focus. Traditional academic venues will be complemented with alternative modes of dissemination to propagate change. To support the ultimate vision of a dynamic learning health system, the ACE unit will continue to monitor emerging trends affecting educational processes (such as artificial intelligence) and continue to partner with other agencies to incorporate new objectives into ongoing innovation efforts.

Building on its work to accelerate change in UME, the AMA recently established the Reimagining Residency initiative—a new five-year, $15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training. The goal of the initiative is to align residency training with the needs of patients, communities, and the rapidly changing health care environment. Grants are intended to promote systemic change in GME and support bold, creative innovations that provide a meaningful and safe transition from UME to GME, establish new curricular content and experiences to enhance readiness for practice, and support well-being in training. With a focus on collaboration, the initiative aims to inspire cooperation among the distinct entities responsible for oversight of GME, including medical schools, GME sponsors, and health systems. Furthermore, Reimagining Residency grant recipients will join the ACE Consortium, further expanding the AMA's community of innovation to allow for broad collaboration and dissemination of ideas across the medical educational continuum, as well as providing an independent focus on creating the residency programs of the future.

THE NEED FOR CONTINUED AMA SUPPORT OF MEDICAL EDUCATION

The ACE initiative has served to anchor the AMA as a leading force in UME innovation, and the forthcoming, unprecedented investment in GME is expected to echo and amplify that impact. Yet much work remains. Medical education is a complex process involving interaction among multiple systems with competing drivers. Systematic change requires a voice that advocates across stakeholder groups in order "promote the art and science of medicine and the betterment of public health." The success of past initiatives and the potential for future innovation speak to the need for ongoing attention to educational trends and support for innovative educational initiatives.

APPENDIX A: CONSORTIUM SCHOOLS (COHORTS 1 AND 2) AND SCHOOL PROJECTS

Table A-1
Consortium member institutions, brief descriptions of site-based projects, and alignment with ACE objectives.

School	Description of project	Competency-based	Health systems science	Learning Environment
Joined the consortium in 2013				
Brody School of Medicine at East Carolina University	Designed and created its Teachers of Quality Academy. Graduates have become a cohort of master educators on patient safety and quality improvement.		X	X
Indiana University School of Medicine	Developed a novel virtual health systems curriculum framed by the structures, policies, and evaluative mechanisms of its health system partners and grounded in a common e-patient panel accessed through the Regenstrief EHR Clinical Learning Platform.		X	X
Mayo Clinic Alix School of Medicine	Developed a four-year health systems science blended learning curriculum. Amplified efforts in student well-being.		X	X
New York University School of Medicine	Created "Health Care by the Numbers," a flexible, technology-enabled curriculum to train medical students in using big data.		X	X
Oregon Health & Science University School of Medicine	Implemented a novel, rigorous, learner-centered competency-based curriculum that allows students to pursue a broader array of interests, shifting the focus toward what students learn rather than what appears on a given exam.	X		X
Pennsylvania State University College of Medicine	Launched a curriculum combining a course in health systems science with an immersive experience as a patient navigator.		X	X
University of California, Davis, School of Medicine	Established a model three-year education track and implemented it in close collaboration with the largest health care provider in the region.			X
University of California, San Francisco, School of Medicine	Created a three-phase, fully integrated curriculum, crafted to enable students to contribute to improving health care outcomes as they learn to work within complex systems and advance science.	X	X	X

University of Michigan Medical School	Assigns students to an M-Home learning community for their four years of medical school. Students achieve competency in leadership through activities integrated with other core curricular components—all while developing change management experience in health care scholarly concentrations.	X		X
Vanderbilt University School of Medicine	Established "Curriculum 2.0," which uses flexible, competency-based pathways to create master adaptive learners trained in health systems science, able to adapt to the evolving needs of their patients and the health care system throughout their careers.	X	X	X
Warren Alpert Medical School of Brown University	Developed nine new courses that constitute the basis for a Master of Science degree in population medicine for its medical students.		X	
Joined the consortium in 2016				
A.T. Still University-School of Osteopathic Medicine in Arizona	Promotes early exposure to health care needs and social determinants by embedding medical students in urban and rural community federally-qualified health centers across the country and empowering student-led systems solutions.		X	X
Case Western Reserve University School of Medicine	Places students in interprofessional teams where they manage and assess the needs of patients at high-performing patient-centered medical homes.		X	X
CUNY School of Medicine	Created a combined a seven-year BS/MD program, preparing students to become primary care physicians in medically underserved areas.			X
Dell Medical School at the University of Texas at Austin	Designed and implemented a curriculum focused on servant and collaborative leadership along with training in health systems science and adaptive expertise.		X	X
Eastern Virginia Medical School	Teaches health systems science, along with basic and clinical sciences, through a case-based, integrated approach using a virtual community of culturally diverse families and associated electronic health records.		X	X

Emory University School of Medicine	Standardized instruction on quality improvement and patient safety across the medical education continuum, including all medical students, residents, fellows, faculty, affiliated physicians, and interprofessional colleagues.		X	X
Florida International University Herbert Wertheim College of Medicine	Created a program where students are assigned to an interprofessional team comprised of students from nursing, social work, and/or physician assistant studies. Competency-based assessments using EPAs to monitor readiness for residency.	X	X	X
Harvard Medical School	Reorganized its entire curriculum using active-learning models, creating a mastery-oriented culture as opposed to a performance-oriented culture.			X
Michigan State University College of Osteopathic Medicine	Launched its “First, Do No Harm” curriculum that incorporates patient safety concepts longitudinally across undergraduate and graduate medical education.		X	X
Morehouse School of Medicine	Increased its class size and its community-based sites, and established learning communities designed to ensure the development of strong longitudinal faculty-student and student-student interactions to facilitate the professional transition process.			X
Ohio University Heritage College of Osteopathic Medicine	Launched “Value-Based Care,” an innovative, competency-based program that integrates primary care delivery and medical education.	X	X	X
Rutgers Robert Wood Johnson Medical School	Incorporates medical students and other health-profession learners into care coordination teams at an affiliated health system’s accountable care organization.		X	X
Sidney Kimmel Medical College at Thomas Jefferson University	Implemented the Regenstrief EHR Clinical Learning Platform and interprofessional health care delivery team educational experiences.		X	X
University of Chicago Pritzker School of Medicine	As part of its patient safety and health care quality curriculum, created a “Room of Horrors” simulation, in which students must recognize common hazards to patient care.		X	

University of Connecticut School of Medicine	Created a curriculum that incorporates the Regenstrief EHR Clinical Learning Platform and brings teams of medical students together across all four years with dental students and other interprofessional partners to learn core skills.		X	X
University of Nebraska Medical Center College of Medicine	Moving interprofessional education beyond the traditional classroom setting and into clinical training environments where it can be applied for the benefit of patients and populations.		X	X
University of North Carolina School of Medicine	Instructs students in quality improvement techniques focused on specific common clinical problems, positioning students to complete quality improvement projects benefiting the clinics in which they train.		X	X
University of North Dakota School of Medicine and Health Sciences	Incorporates advanced simulation and telemedicine into education about providing care to those in rural or remote communities.		X	X
University of Texas Rio Grande Valley School of Medicine	Incorporates tablet computers into a curriculum that nurtures communication skills specific to working with disadvantaged populations.			X
University of Utah School of Medicine	Adapting tools proven effective at bending the cost curve of health care to create a new educational model that emphasizes cost reduction and improves undergraduate medical educational outcomes.		X	X
University of Washington School of Medicine	Implemented a new curriculum structure across its sites in Washington, Wyoming, Montana, Alaska, and Idaho, enhancing clinical training during the basic science years and basic science in the clinical years.			X

APPENDIX B: COMMON CURRICULAR CHANGES AT MEMBER INSTITUTIONS

Principal investigators at all 32 schools were asked about common curricular interventions, including content and structural elements. Respondents indicated the state of each element prior to, and at the conclusion of, the grant, with the following response options:

- Absent, no plans to implement
- Absent, but plans underway to implement
- Newly implemented
- Progressing implementation
- Mature implementation
- Abandoned implementation (only one incident was reported of abandoning a topic)

The tables provide the most common response (mode) for each topic at pre- and post-grant.

Table B-1

Curricular Element	**Most common pre-grant status**	**Most common post-grant status**
Leadership and change agency	Absent, no plans	Progressing implementation
Health care economics	Absent, no plans	Progressing implementation
Clinical informatics and health information technology	Absent, no plans	Progressing implementation
Value-based care	Absent, no plans	Progressing implementation
Systems thinking	Absent, no plans	Progressing implementation
Master adaptive learner skills	Absent, no plans	Progressing implementation
Patient safety	Newly implemented	Mature implementation
Quality improvement	Newly implemented	Progressing implementation
Teamwork/inter-professional care	Newly implemented	Progressing implementation
Health care policy	Progressing implementation	Mature implementation

Table B-2

Structural Element	**Most common pre-grant status**	**Most common post-grant status**
Med student coaching	Absent, no plans	Absent, but plans underway to implement
Flexible individualized learning plans	Absent, no plans	Progressing implementation
Competency-based education	Absent, but plans underway to implement	Progressing implementation
Assessment readiness for internship	Absent, but plans underway to implement	Progressing implementation
Optimizing the learning environment	Absent, but plans underway to implement	Progressing implementation
Medical student wellness	Newly implemented	Mature implementation

APPENDIX C: COLLABORATIVE OUTPUTS OF ACE

This appendix provides more detailed descriptions of collaborative efforts and institutional exemplars of implementation.

Health systems science

One of the earliest innovations to emerge from the work of the consortium was the articulation of the concept of health systems science (HSS) as the third pillar of medical education, complementing the traditional focus on basic sciences and clinical skills. ACE members recognized that learners must understand how health systems deliver care to patients, how patients receive and access that care, and how to improve those systems. Experts from consortium member schools collaborated to write the *Health Systems Science* textbook, published by Elsevier in December 2016 (see text users in tables 5 and 6 below). ACE members collaborated with the National Board of Medical Examiners to create a HSS subject exam and to incorporate this content into the USMLE Step exams. A student-led thematic meeting in support of the HSS construct, "Patient-Centered Care in the 21st Century-Health Systems Science Through the Medical Education Continuum," was held at Penn State College of Medicine in August 2018. A total of 87 students, residents, faculty members and staff from 27 consortium schools attended.

Table C-1
Users of the Health Systems Science textbook

Consortium member schools	
The Warren Alpert Medical School of Brown University	Required for the Primary Care-Population Medicine program
Case Western Reserve University School of Medicine	Used throughout the MD curriculum.
CUNY School of Medicine	Used in the longitudinal clinical experience
Morehouse School of Medicine	Fundamentals of Medicine (supplement)
Oregon Health & Science University	MD Program, required
Pennsylvania State University College of Medicine	Required for Science of Health Systems courses
University of California, San Francisco, School of Medicine	Clinical and Systems Applications, supplementary text
University of Nebraska Medical Center	Longitudinal Health Systems Sciences course
University of Utah	Pathway in value/health systems
University of Washington	Reference text for the Ecology of Medicine course.
Vanderbilt University	Foundations of Health Care Delivery (FHD); all four years; also used for the pediatric GME program
Vanderbilt University Medical Center	Health Policy, supplementary. (business school)
Non-consortium medical schools, other educational institutions, and other entities	
Arizona College of Osteopathic Medicine- Midwestern University	Required for a Health Systems/Health Policy Research elective
Boise State University	Used in a nursing course
California State University, Long Beach	HCA 416 Management & Info Systems

Cedars-Sinai Medical Center	GME/Epidemiology, required
Columbia University	Supplementary, Leading Quality Improvement in Healthcare
Drexel University	Frontiers IV (recommended)
Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo	AOA Leadership Track, year 2 curriculum - understanding health systems
Lock Haven University	Professional Topics Seminar/PA program
MITRE Corporation	Resource for members of the health care consulting unit
Rosalind Franklin University	Patient Safety Elective Course/Supplemental reference text used in parts in various courses, M1 and M2 years.
San Antonio Uniformed Services Health Education Consortium	Supplement to the Introduction to Quality Improvement and Patient Safety
Shenandoah University/Byrd School of Business	Health business courses
St. Anthony Hospital	GME/required
TDC Labs	Resource for entrepreneurs
Uniformed Services University F. Edward Hebert School of Medicine	Medical courses
University of Kansas Medical Center	Not used in a course; used as a resource for Scholarship and Enrichment week
University of South Carolina School of Medicine, Greenville	Integrated Practice of Medicine, used as faculty resource
Western Michigan University Homer Stryker MD School of Medicine	Residency training
William Carey University	Doctoring Skills & Clinical Science (recommended textbook)
Wright State University	Upstream Medicine

Value-added roles for medical students

Incorporating pragmatic experiences regarding HSS into curricula enhances opportunities for students to add value to the health system. At Penn State College of Medicine, students spend nine months as patient navigators embedded in transitional care programs, primary care clinics, specialty-based clinics, underserved free clinics, and nursing homes. Student navigators guide patients through the complex health continuum, providing information, patient education, emotional support and coordinating community care. Student navigators use the resulting insights to assist in implementing new processes to enhance safety, efficiency, and the patient experience.

Case Western Reserve University School of Medicine modified Penn State's patient-navigator model to work with specific populations and focus more on care coordination. Rutgers Robert Wood Johnson Medical School incorporated medical students and other health-profession learners into care coordination teams at the Robert Wood Johnson Partners Accountable Care Organization (ACO). Medical students at the University of California, San Francisco are immersed in a longitudinal, interprofessional and authentic clinical microsystem and play a role in improving patient experience and health care quality while learning and applying clinical skills.

Medical students embedded in the community

Students at CUNY School of Medicine are embedded at numerous federally-qualified health centers. During the first year, students shadow physician preceptors and develop their clinical history-taking skills. They also learn about team-based care and rotate with nurses, dieticians, and social workers in order to understand how each professional contributes to patient care. Medical students are trained as health coaches and help patients implement health-related behavioral changes, such as exercise and diet changes. Students return to the same health centers during the following two years of their longitudinal clinical experience and assist with value-added tasks, such as medication reconciliation and developing and disseminating patient education tools. Students act as navigators accompanying patients through all points of their clinic visit and begin to identify the multiple points of care, the various members of a health team and their specific roles, ranging from the front desk, to nursing/triage staff, the physician, pharmacists, social workers, and nutritionists.

A.T. Still University-School of Osteopathic Medicine in Arizona has partnered with the National Association of Community Health Centers to place second through fourth-year medical students in 12 rural and urban community health centers. These longitudinal experiences provide contextual learning about the social determinants of health and other aspects of HSS as well as the basic and clinical sciences.

Florida International University Herbert Wertheim College of Medicine (FIU) built on its "Green Family Foundation Neighborhood Health Education Learning" program (NeighborhoodHELP™). During the second, third, and fourth years, students become part of teams of interprofessional students going into households to take care of underserved families. FIU was host to "Community Medical Education: From Engagement to Development," a thematic meeting attended by 47 people from 28 consortium schools.

Patient safety and quality improvement

Patient safety and quality improvement are two other key topics included within HSS, and several schools developed a sharp focus on these domains. The University of Chicago Pritzker School of Medicine incorporates active learning in patent safety and health care quality into all four years of medical school and uses novel technological tools to do so. These tools include an online microblogging learning community with trained faculty coaches, point-of-care applications on mobile devices and a "Room of Horrors" filled with some of the scariest hazards to patient care. The Room of Horrors has been replicated by at least five medical schools and was featured at a sold-out event during Chicago Ideas Week, September 2018.

Students at Vanderbilt University School of Medicine have completed over two hundred quality improvement projects. Identifying needs over the course of their clinical experience, students complete a mentored process under the guidance of quality experts to create interventions with defined outcome metrics to ensure alignment with the priorities of the health care system. Recognizing that similar improvement efforts were occurring at multiple consortium sites, the AMA sponsored a student impact challenge in 2018. Over 40 high-impact projects were submitted, and cash prizes were awarded to 3 students.

But before medical students can be taught the competencies associated with patient safety and quality improvement, medical school faculty must learn how to teach these relatively new areas of focus in medicine. Brody School of Medicine at East Carolina University designed and created its Teachers of Quality Academy (TQA). Those who have graduated from the program have become a cohort of master educators on patient safety and quality improvement and have helped advance

these subjects across the campus and health system. Emory University School of Medicine implemented a faculty development program around patient safety and quality improvement that offers multiple options for engagement. Quality improvement training and related projects can be used to meet maintenance of certification requirements. The AMA launched a Health Systems Science Faculty Academy in September 2018 with 39 participants. In the future, the Academy will be open to consortium and non-consortium schools.

Social determinants of health

Social determinants of health, one of the domains of HSS, is a focus at some consortium member schools. The University of California, Davis, School of Medicine launched a three-year education track, the Davis Accelerated Competency-based Education in Primary Care (ACE-PC) program, in close collaboration with Kaiser Permanente of Northern California, the largest health care provider in the region. Addressing social determinants of health is central to the program's mission and curriculum. UC Davis ACE-PC students are embedded into Kaiser Permanente's integrated health care delivery system and patient-centered medical home model from the first week of medical school. Davis was the host of "Health Equity & Community-based Learning: Students as Advocates," a student-led thematic, in August 2016 that was attended by over 200 medical education leaders, medical students, and students from other health professions.

Chronic disease

In recognition of the fact that medical care is increasingly focused on chronic disease rather than acute conditions, several consortium projects have focused on shifting medical education in this direction. For example, the medical students incorporated into the ACO at Rutgers Robert Wood Johnson Medical School augment care for patients with multiple chronic conditions. Chronic disease management is a core component of the ACE-PC program at Davis. The curriculum at Eastern Virginia Medical School includes a focus on care for patients with multiple chronic conditions. The Accelerating Change in Medical Education initiative has held several meetings with Improving Health Outcomes, another of the AMA's strategic focus areas, to work toward developing medical school coursework on chronic disease.

Competency-based Medical Education and Individualized Pathways

Member institutions of ACE had varying levels of engagement in implementing competency-based approaches. At some sites, changes were limited in scope to specific interventions such as establishing intern-prep courses or defining competencies in specific curricular realms such as HSS. A subset within the consortium, however, worked closely together to advance more significant implementation of CBME and individualized pathways. Interestingly, four of the ten schools invited to the AAMC's national pilot of the Core Entrustable Professional Activities for Entering Residency (Core EPAs) were ACE Consortium schools (FIU, OHSU, NYU and Vanderbilt).

Although ACE members have not yet achieved time-variable advancement to GME, several sites did create the capacity for individualized pathways informed by competency development. At Vanderbilt, students receive feedback in all competency domains starting in the first weeks of school and complete evidence-driven personalized learning plans in a structured process supported by faculty coaches. The requirements of the post-clerkship phase can be adjusted to match the competency needs of the individual, with some students requiring more clinical skill development and others focusing on foundational sciences, while students who have attained all competency expectations are permitted full flexibility to pursue personal goals. In a similar structure, OHSU utilized competency evidence and coaches to permit some students to graduate early. Although

these students were not able to immediately enter GME, they did reduce their tuition burden. Michigan uses the analogy of a tree's trunk and branches to illustrate the relationship of core competencies expected of all students to the individualized pathways that prepare students for future leadership roles.

These sites serve as important exemplars for a challenging implementation process. Their collective experience has positioned the AMA and ACE to contribute with authority to the international call for a greater focus on educational outcomes over educational process.

Optimizing the Learning Environment

The consortium has not just been focused on what medical students learn, but also how they learn. The learning environment includes several components: personal, social, organizational, and physical / virtual.[67] ACE schools have implemented changes at all these levels to promote student success.

Well-being

Concerns for student well-being was a shared priority among members of the consortium. Many of the curricular innovations implemented across ACE sites are designed to enhance the learner's experience and thus mitigate against the dehumanizing impact of traditional training. However, it was also acknowledged that adjusting to new models can be distressing to students. Mayo Clinic Alix School of Medicine has been a leader in the realm of physician and student wellness and lead an inventory across consortium schools to identify current practices. Consortium members attacked this issue from several perspectives: assessing student distress, implementing supportive programs, defining the competencies students need to effectively manage wellness throughout their careers. Importantly, the group facilitated a shift to focus beyond the individual to align with the AMA's vision that wellness is a structural issue. Training in HSS and master adaptive learning techniques will prepare students to take control of their practice environments in the future.

Master adaptive learner

Although entering medical students may consider themselves expert learners, their prior environments were structured, with learning objectives and outcomes defined by their teachers. Successful lifelong learning requires differing strategies to juggle learning alongside the competing demands of daily practice. To illustrate this point, experts from several consortium schools such as Vanderbilt University School of Medicine, University of Michigan Medical School, Oregon Health & Science University School of Medicine (OHSU) and New York University School of Medicine developed the conceptual model of the *master adaptive learner*. Physicians who are master adaptive learners adapt to the evolving needs of their patients and the health care system throughout their careers by engaging in guided self-assessment and cyclical learning plans. Several sites introduced this model to their students and implemented authentic workplace-based opportunities to practice identifying and addressing individual learning needs.

Coaching

Coaching and the use of coaches is a key factor that supports the development of master adaptive learner. Unlike an adviser or a mentor, an academic coach may or may not have expertise in the realm of the self-identified need(s) in their learner but is skilled at helping the learner accurately reflect on their performance, their needs for growth, and gain insight into desired outcomes. Coaches help learners improve their own self-monitoring. In order to disseminate the coaching concept, the consortium published Coaching in Medical Education, A faculty handbook on the AMA website and made it freely available (log-in required). A total of 7,457 components of this

book were downloaded from the website. More than a thousand copies were mailed to medical schools for distribution. A thematic meeting focused on coaching was offered in October 2018 and attended by 81 people from 30 consortium schools.

Technology

Very little of the innovations described throughout this report could happen without the best technology infrastructure. Many of the ACE schools implemented new learning management systems to better support interactive and team-based learning. Digital platforms are critical to assemble and display the performance evidence that supports competency-based approaches to medical education. For example, at Vanderbilt, a rich informatics and technology infrastructure collects learner experiences and assessments in the learning portfolio and aggregates and displays performance data in a way that facilitates interpretation and decision-making for personalized learning plans. At OHSU, competency milestones achieved by medical students are tracked in a web-based personal portfolio, and students receive badges for their achievements. Learners can monitor their progress toward preparing for the expectations of internship in real time and can track relative progress across various domains of competency.

Training students to effectively use technology in practice is also critical. Indiana University School of Medicine (IUSM), in conjunction with the Regenstrief Institute, developed the Regenstrief EHR Clinical Learning Platform. This EHR, designed specifically for teaching, is a clone of an actual clinical EHR, using de-identified and misidentified real data on more than 10,000 patients. This platform allows medical students, starting in week one of medical school, to write notes and orders, view data on patients, and access just-in-time information links. It provides a safe and realistic health system environment from which to learn and practice clinical decision-making skills and is a resource to address learning gaps and assist students in meeting competency-based expectations. Students work within a virtual health system and use the Regenstrief EHR to identify errors and patient safety issues; initiate quality improvement and measure the success of these efforts; explore the potential for personalized medicine; and gain comfort in comparing their own practice patterns with those of their peers. Students “care” for a panel of e-patients and, blinded to the real care provided, have the ability to compare their diagnosis and treatment recommendations to those of their health student colleagues and to the actual attending provider, as well as experience firsthand the utility, power, versatility, and challenges of using health information technology to deliver cost-effective, quality health care.

The Regenstrief EHR Clinical Learning Platform was adopted by consortium and non-consortium schools, including several who built up and expanded upon this tool. The University of Connecticut School of Medicine, a consortium member, incorporated the Regenstrief EHR Clinical Learning Platform into its new “MDelta” curriculum and expanded the IUSM registry of real de-identified and misidentified patients with its collection of virtual patients and families. Sidney Kimmel Medical College at Thomas Jefferson University integrated the Regenstrief EHR Clinical Learning Platform into an interprofessional health care delivery team educational experience that all Jefferson College of Medicine, College of Nursing, College of Pharmacy, and College of Health Professions students participate in during their first two years.

New York University School of Medicine created “Health Care by the Numbers,” a flexible, technology-enabled curriculum to train medical students in using big data—extremely large and complex data sets—to improve care coordination, health care quality and the health of populations. This three-year blended curriculum is founded on patient panel databases derived from de-identified data gathered from NYU Langone’s outpatient physician practices and government-provided open data from the 2.5 million patients admitted each year to New York State hospitals. A

total of over five million de-identified patient level records are available for student projects. Students can explore every inpatient admission by DRG code, providers, charges, or hospitals. The data set is continually expanded and refined. The technology infrastructure for the NYU Health Care by the Numbers curriculum is open to the public at: http://ace.iime.cloud.

Evaluation

Evaluation has been a pivotal piece of the AMA's Accelerating Change in Medical Education initiative since its inception. The objectives of the overall initiative and the work at each site are founded upon current educational theory. Significant resources have been invested in the interventions that have been implemented, and consortium members acknowledge the duty to critically appraise outcomes. In addition to the internal evaluation plans at each site, experts from the member institutions collaborated to determine measures of success for the collective. The group has committed to advancing educational scholarship. The following section elaborates on these outcomes.

APPENDIX D: IMPACT ON LEARNERS

Case Western Reserve University Medical School

Twenty medical student navigators were partnered with refugee families at Neighborhood Family Practice, a federally qualified community health center on Cleveland's west side, during the current grant year. These students all forged relationships with their families over the course of the year, however 4 pairs of students have served as inspirations to all of us, demonstrating how care should be provided for all patients. They partnered with families who escaped war in Syria, Afghanistan, and Ethiopia. Each of these 3 medical student navigator pairs partnered with a newly arrived refugee family facing serious health issues in addition to transitioning to a new country, culture, and language. They embraced the notion of creating authentic trusting relationships by employing cultural humility and gaining the trust of their partner families. These students approached each family with kindness and attentiveness to their most pressing needs in order to eventually address health needs and promoted well-being. Additionally, they seamlessly integrated themselves into the primary care team, becoming trusted among colleagues and even consistently documenting in the electronic medical record.

Two medical student navigators partnered with a mother and adult daughter from Afghanistan who experienced serious trauma as a result of war. While the mother had been dismissed by some physicians as having "somatic complaints," the navigators attended specialty and primary care appointments to articulate all of her concerns in the context of her past trauma, living situation, and profound social determinants of health. The students facilitated treatment for a bedbug infestation in their home, new health insurance when she and her daughter were dis-enrolled, and coordinated with the pharmacy when multiple medication were not filled due to insurance and communication errors. They also helped the family obtain clothes and food when those basic resources were scarce and advocated for transition to a new case manager and trauma therapist when they determined her case had been sub-optimally handled by one agency. They ultimately assisted in making the diagnosis of rheumatoid arthritis leading to more effective systemic treatment options rather than continued dismissal as trauma related somatic complaints. They accomplished all of this while using an interpreter to communicate in Dari. This family has repeatedly shared their gratitude for the role the navigators have played in this difficult transition to the U.S.

University of North Dakota School of Medicine and Health Sciences

From a student in the program:

I felt nervous but excited to attend the simulation. I did not know what to expect. When I walked into the room, the role play began immediately. I was thinking there would have been a brief discussion of roles, but it started right away, which turned out to work out. I introduced myself to the granddaughter, and the patient in the nursing home. During the first two role plays, I felt like I did really well about talking directly with Sandra, the patient in the nursing facility, and then also talking to the granddaughter and explaining resources. I felt like that was good to do to get a better understanding of the client's cognitive level of functioning, and awareness, but also to maintain her dignity and respect by talking to her. During the second session role play, I felt like I didn't do as good of a job interacting specifically with the patient, but was more focused on the granddaughter, and learning her coping skills, supports, and informing her of services and supports.

One thing I did initially think about was that as a social worker, I typically have several resources available to give out. I was pretending to give the granddaughter brochures to review during the role play. I know I learn better from both hearing about things, but also being able to look at things, and reflect on it, and let it sit, rather than make a decision in a minute. I think in real life, without providing too much as to overwhelm the person, social workers would have resources available for the person to review. I thought about if it would be helpful to have a sample DNR to have at the simulation to review, and to tell the family, there are different types available, but that these are some of the typical questions and things to consider.

I think I need to get better with physical touch. I am really mindful about use of self and touch, and some people don't like it, while others really do, and I think in a hospital setting, depending on the situation, touch may be important. Touch, I can see, would be challenging when using telemedicine/teleconferencing in this setting. This simulation made me thing about doing telecounseling, and what that may look like, and how there could be ways to create connections depending on the population. For example, when working with youth, after rapport is established, to do a soft fist bump or something to the screen at the same time, in lieu of a handshake, or other techniques to help make a "physical connection."

Lastly, one thing I didn't say during the role play, but thought of after when talking with a classmate was that I regret not mentioning or bringing up if there was any cultural, religious, or spiritual practices that they wanted us to be aware of. I think that is really important to be cognizant of. Along those same lines, I also think it is important to be aware of how individuals learn. I know that is one thing the nurses locally have been asking is how people prefer to learn new things/learn to take their medications/learn how to do their own treatment, whether it is reading written information, watching demonstrations, or hearing/being told how to do something. I think this is important to ask so we know we are getting the client and family the information in inclusive ways.

I really enjoyed the simulation, and I would be open to participating in others. I liked how there was one session without the OT and then how the next one the OT was there. It gave me and the team good insight about what their role was. I wonder how it would be if there was one simulation without a social worker, and then the next one with a social worker, and how the team would see the difference. This role play did peak my interest in hospital social work and prompted me to do more learning on advanced directories and living wills for myself, and also for people I may work with.

APPENDIX E: IMPACT ON FACULTY

Researchers at the Brody School of Medicine at East Carolina University created the Redesigning Education to Accelerate Change in Healthcare (REACH) program, comprised of three separate but interconnected parts: 1) Teachers of Quality Academy (TQA); Leaders in Innovative Care (LNC); Longitudinal Core Curriculum (LCC). The TQA is a faculty development program that has been designed to increase the pedagogical and leadership capacity of faculty in HSS, specifically within the areas of quality improvement, patient safety, population health, and interprofessional education. Focusing upon both content and process across the medical education continuum, the TQA aims to achieve excellence in health care delivery through dedicated training and application of team-based, patient-centered care.

To date, there have been 78 graduates from the Academy, 18 of whom have received promotions. There have been opportunities for interinstitutional collaboration – for example, between Brody, Penn State, and Case Western – resulting in a draft health systems science assessment tool and refinement of a health systems science longitudinal curriculum. An annual quality improvement and medical education symposia series have been established as well as seminars, cross campus collaborations, opportunities for mentoring, and clinical experiential applications. TQA graduates shared their personal philosophies which include:

> *I want to be known for being an approachable, optimistic, trustworthy leader so that I can deliver innovative, productive, and compassionate care.*
>
> *I want to be known for being respectfully decisive and sincerely optimistic so that I can deliver meaningful results based on competent analysis.*
>
> One graduate summarized the experience in the following way:
>
> *TQA was one of the most comprehensive learning experiences I've participated in. Learned much more than I expected. Collaboration with others in the group was a great benefit learned. Thank you to the leaders and course coordinators.*

APPENDIX F: IMPACT ON THE AMA

Table F-1

Top 10 AMA Wire titles	**Pageviews**
Not your grandfather's med school: Changes trending in med ed	8,610
3 big ethical issues medical school doesn't prepare you for	6,279
New textbook is first to teach "third pillar" of medical education	6,023
Video games are changing medical education	5,683
Why medical schools are building 3-year programs	5,647
Pre-residency boot camps prep med school grads for new realities	4,420
Tailor-made plans help M4s get more out of last year before GME	4,221
At these 3 med schools, health systems science is core component	4,040
New approach equips med school grads for tomorrow's health system	4,016
Advice for a med student's must-have—a sound night's sleep	3,920
Total page views from 10/26/16 to 9/28/18	**193,992**

Table F-2

2017 Webinars	**Date (2018)**	**Participants**
Inter-Professional Education	Jan 29	250
Student Wellness	March 19	296
Student Leadership	May 21	171
Student Portfolios	July 30	178
Health Systems Science in MedEd (US/South Africa)	Aug 13	77
Value-Added Roles for students	Sept 17	89
Leadership in HSS (US/South Africa)	Nov 1	46
		Total Participants: 1107
2018 Webinars	**Date (2018)**	**Participants**
Regenstrief Teaching Virtual EHR	4/24/2017	204
Educause Collaboration	6/5/2017	N/A
Big Data for Population Health	8/21/17	199
Health Systems Science	10/23/17	186
Inter-Professional Education	1/29/18	250
Student Wellness	3/19/18	296
Student Leadership	5/21/18	171
Student Portfolios	7/30/18	178
Health Systems Science in MedEd (US/South Africa)	8/13/18	77
Value-Added Roles for students	9/17/18	89
Leadership in HSS (US/South Africa)	11/1/18	46
		Total Participants: 1696

Table F-3

Virtual Discussion	Date	Participants
Teaching Virtual EHR	4/24/17	51
Transforming education: Leading innovations in health professions education	5/29/17	74
Interprofessional Education: Challenges and Solutions	7/13/17	76
Reflections on the ACE Student Leadership Meeting	8/3/17	24
Using Big Data to Teach Population Health	8/17/17	36
ChangeMedEd® 2017 Discussion Forum	9/13/17	62
Health Systems Science – The Third Pillar of Medical Education	10/17/17	91
Implementing a Successful Academic Coaching Program for your Learners	12/4/17	135
Sexual Harassment of Learners in the Clinical Environment	1/16/18	111
Interprofessional Education: Using technology to teach team-based care	1/29/18	130
Medical Student Wellness and Beyond: Creating a Healthy Culture for All	3/19/18	264
Recruiting for Diversity: Recognizing Visible and Invisible Strengths	4/23/18	133
Developing the Next Generation of Physician Leaders	5/21/18	139
Enhancing Medical Student Experiences in Light of the New CMS Policy for EHR Documentation	6/11/18	213
Portfolios and Dashboards: Leveraging Data for Student Success	7/30/18	194
How Can Medical Students Add Value to Patient Care in the Health System?	9/17/18	115
MedEd Makeover: Making Room in a Crowded Curriculum	10/22/18	170
		Total Participants: 2018

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-A-19

Subject: For-Profit Medical Schools or Colleges

Presented by: Carol Berkowitz, MD, Chair

American Medical Association (AMA) Policy D-305.954, "For-Profit Medical Schools or Colleges," states:

> That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting.

This policy resulted from Resolution 302-A-18, introduced by the Illinois Delegation. During the hearing, the reference committee heard testimony in favor of conducting this study.

The Council on Medical Education recognizes the importance and timeliness of this topic and agrees that appropriate resources and data collection are needed to study this issue and prepare the report. However, meaningful and constructive review of this issue and the data collection will require additional time. The Council therefore will present a report on this issue at the 2019 Interim Meeting of the House of Delegates.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-19

Subject: Drug Shortages: 2019 Update

Presented by: Robyn F. Chatman, MD, MPH, Chair

INTRODUCTION

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States (see Appendix 1 for policy). This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2017 to February 2019, using the text term "drug shortages." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the US Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine (NASEM), American Society of Health-System Pharmacists (ASHP), Pew Charitable Trusts, Duke Margolis Center for Health Policy, the Institute for Safe Medication Practices (ISMP), and by direct contact with key FDA, ASHP, and Utah Drug Information Service staff who monitor drug shortages and related issues daily.

BACKGROUND

The CSAPH has issued nine reports on drug shortages.[1-9] The findings and conclusions of the first five reports are summarized in CSAPH Report 2-I-15, "National Drug Shortages: Update."[4] The remainder of this report will update information on drug shortages since the 2018 report was developed, specifically commenting on the new initiatives to identify the root causes of drug shortages.

CURRENT TRENDS IN DRUG SHORTAGES

Drug shortages remain an ongoing public health concern in the United States. The rate of new shortages is increasing and common shortages are severely impacting patient care and pharmacy operations. Ongoing supply challenges of certain medications, typically older, generic, injectable products that are off-patent and have few suppliers (usually three or fewer), persist. Long-term active and ongoing shortages are not resolving and the most basic products required for patient care are in shortage, including bupivacaine, lidocaine, hydromorphone, morphine, fentanyl, ketamine, ondansetron, saline, and sterile water. Causes of shortages continue to remain largely unchanged and are mostly triggered by quality problems during manufacturing processes.

The two primary data sources for information on drug shortages in the United States continue to be the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug Information Service (UUDIS). According to the most recent data compiled by ASHP and UUDIS, in 2018 there were a total of 306 active shortages, with 186 of those being new (compared to 2017 which saw 303 active and 146 new shortages). Each quarter since the third quarter of 2017 saw an increase in drug shortages. The top five classes of drugs implicated in active drug shortages include CNS medications (43); antimicrobials (33); electrolytes, nutrition, and fluids (31); cardiovascular medications (23); and chemotherapy agents (16). The reasons for drug shortages vary and unknown/unreported reasons account for 51 percent of drug shortages. Manufacturing issues account for 30 percent of shortage issues and drug discontinuation increased to 10 percent of shortage issues in 2018 compared to 4 percent in 2017. (See Appendix 2 for ASHP/UUDIS data).[10]

The fifth annual report on drug shortages from the FDA to Congress published in June 2018, summarizes the major actions the FDA took in calendar year 2017 related to drug shortages.[11] Notably, using a range of available tools, the FDA worked with manufacturers to successfully prevent 145 shortages during 2017.[11]

The FDA continues to utilize a mobile app to provide up-to-date access to drugs in shortage as well as notifications about new and resolved drug shortages and gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a current shortages list, mobile app, and additional information (Box 1).[12] The ASHP Shortage Resource Center provides a list of shortages, guidance on managing critical shortages, as well as shortage metrics (Box 1).[13] Additionally, a recent publication details ASHP guidelines for managing drug product shortages and provides a framework for healthcare teams in patient care to develop policies and procedures that minimize the effects of drug shortages on quality of care.[14]

CURRENT DRUG SHORTAGE ACTIVITIES

National Academies of Sciences Engineering Medicine Workshop, Medical Product Shortages during Disasters: Opportunities to Predict, Prevent, and Respond

In September 2018, the AMA participated in a NASEM-convened workshop, Medical Product Shortages during Disasters: Opportunities to Predict, Prevent, and Respond, to better understand the gaps that lead to cascading effects in patient care throughout the U.S. health care system when shortages of medical devices, drugs, and supplies occur in the context of disaster (not day-to-day shortages).

Discussion topics included the importance of public-private partnerships and a collaborative effort; situational awareness about all elements of the supply chain; the need to identify useful metrics, collect sufficient data, and share it accordingly; the strategic national stockpile; issues with “just-in-time stocking” and shortage cascades; the issues involved in frequent staff (re)training, learning, and alert fatigue; and the impact on patient care including “regression of care” when physicians need to find solutions other than the standard of care. The detailed proceedings from the workshop have been published.[15]

Multi-stakeholder Summit, Drug Shortages as a Matter of National Security: Improving the Resilience of the Nation's Healthcare Critical Infrastructure

In September 2018, the AMA participated in a summit regarding drug shortages as a matter of national security, sponsored by several stakeholders including ASHP, ISMP, the American Hospital Association, American Society of Anesthesiologists, and American Society of Clinical Oncology.
The objectives of the summit were to identify the vulnerabilities of the supply chain that result in drug shortages; define the roles and responsibilities of the public and private sectors for planning and responding to national security events; and identify recommendations to strengthen the current healthcare infrastructure to prevent drug shortages that may result in patient harm.

The meeting brought together representatives from clinician groups, industry and supply chain, and public-sector members to discuss drug shortages as a national security priority. Several recommendations were offered after the discussion as potential policy and marketplace changes that may help prevent and mitigate drug shortages.[16]

Some of the recommendations discussed at length included:

1. The need for greater understanding of the drug supply chain from beginning to end, including clarity of raw material sources, overall quality of production, and greater transparency from manufacturers;
2. Development of management models using data science as well as the need to identify the relevant metrics related to the drug supply chain and how to collect and share it
3. Development of an "essential drugs" list;
4. Incentives for manufacturers;
5. Standardization of medication dose, preparations, and size.

U.S. Food and Drug Administration Activities

In a statement from July 2018, FDA Commissioner Scott Gottlieb, MD, and FDA Center for Drug Evaluation and Research Director Janet Woodcock, MD, outlined new efforts the FDA is advancing to address drug shortages – a three-pronged approach that focuses on preventing shortages, early identification of anticipated shortages, and responding to shortages using their current authorities, as well as the creation of an Interagency Drug Shortage Task Force.[17,18]

Interagency Drug Shortage Task Force. An Interagency Drug Shortage Task Force was established by the FDA to identify the root causes of drug shortages and advance potential long-term solutions in a report to Congress. The Task Force will be led by FDA's Associate Commissioner for Strategic Initiatives and will include federal officials from several agencies concerned with drug shortages including the FDA, the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Preparedness and Response, the Department of Veterans Affairs, the Department of Defense, and the Federal Trade Commission.[19]

Currently, in cases of drug shortages, the FDA has a variety of tools to employ to minimize the impact. These include expediting the inspection of a new drug manufacturing facility so it can become operational as soon as possible; expediting the review of a new or generic drug application that, if approved, may help mitigate or prevent a shortage; urging manufacturers of similar or alternative products to ramp up production to meet an anticipated increased demand; and exercising discretion with respect to temporary importation of a product from a foreign manufacturing source until a shortage is resolved. FDA officials have stated that the work of the Task Force will be

"forward-leaning and extensive" with the goal of complementing and strengthening the ongoing efforts of the Agency to establish long-term solutions. Some of the considerations include proposals for possible additions to FDA authorities, evaluation of reimbursement policies of payors, exploration of possible incentives to encourage manufacturing that can expand and ensure a stable drug supply, evaluation of the need for an essential drugs list, and incentives for manufacturing critical drugs.

FDA Listening Session on Drug Shortages. In October 2018, the FDA held a series of invitation-only listening sessions at the FDA. Invitations were extended to a diverse group of stakeholders including medical organizations (such as AMA), pharmacies and hospitals, manufacturing groups, group purchasing organizations (GPOs) and distributors, and experts and think tanks. The goal of the sessions was for the FDA to gather information concerning the economic and clinical impact of drug shortages and to inform the newly formed Interagency Drug Shortage Task Force. AMA staff in attendance provided comprehensive comments regarding AMA policy and the most recent Council on Science and Public Health report from A-18.

The FDA lists four general themes that came from the series of listening sessions:

1. The impacts of drug shortages affect every level of the health care system, ultimately compromising the standard of care, producing waste, and increasing costs.
2. Multiple market factors such as buyer and seller consolidation, low margins, and contracting practices contribute to drug shortages.
3. It is unclear what the right level of transparency is based on manufacturing security concerns, and hospital, pharmacy, and GPO needs. The health care community would like more transparency throughout the supply chain.
4. Multiple federal agencies such as the FDA, Drug Enforcement Administration, and CMS, have different authorities on drugs, which makes it hard for both industry and hospitals to manage. Ideas have been put forth on how agencies can mitigate – but may unintentionally exacerbate – the issues.

FDA Public Meeting: Identifying the Root Causes of Drug Shortages and Finding Enduring Solutions. In November 2018, the FDA Interagency Task Force under a cooperative agreement with the Robert J. Margolis, MD, Center for Health Policy at Duke University, hosted a public meeting for open discussion of the root causes of drug shortages and solutions, which AMA staff attended. The speakers at the day-long public meeting included a broad range of stakeholders.

The FDA's efforts to date have addressed the immediate causes of drug shortages such as manufacturing quality issues, raw material sourcing, business decisions to discontinue products, and marketplace changes. This initiative aims to focus on identifying and remedying systemic, root causes that drive and sustain product shortages and developing enduring solutions to mitigate and prevent drug shortages from occurring.

Little consensus exists regarding the most significant and the largest contributing root causes of drug shortages. A useful discussion guide from this public meeting outlines some of the hypothesized root causes of drug shortages including lacking information to assess drug supply reliability; low profit margins, particularly among generic drugs, causing decreased production and quality; barriers to market entry from manufacturers to address shortages; and additional contributing factors including "just-in-time" manufacturing, contracts and agreements, stockpiling, and increased globalization/limited supply chain options.[20]

Input from this meeting, as well as from listening sessions with stakeholders, and the public docket will be considered during the drafting of a report providing recommendations/guidance that the Task Force plans to submit to Congress by the end of 2019. Potential areas of action might include, but would not be limited to, contracting, tax incentives, increased transparency of manufacturing quality, reimbursement or regulatory changes, as well as any other proposed solutions as appropriate.

Public Docket. FDA had a public docket open to receive stakeholder comments regarding the root causes of drug shortages and possible solutions which closed on January 11, 2019. The AMA submitted comments to the docket outlining our policy and recommendations (Appendix 3).[21]

Quality Metrics. Appropriate quality metrics provide elements of assurance and oversight necessary for pharmaceutical manufacturing and quality control; however, the complexity of the manufacturing process makes the collection and use of metrics difficult. The FDA has taken steps within its regulatory authority to address this issue as it relates to drug shortages by developing a quality metrics program for pharmaceutical manufacturers.[22] Information generated could be used by the FDA to identify drugs at greater risk of shortage and proactively reduce that risk before a disruption occurs.

Manufacturing Modernization. Another FDA initiative encourages manufacturers to adopt advanced manufacturing technologies, such as continuous manufacturing, that increase production reliability and capacity and can assist in medical product shortage mitigation. To support this initiative, the FDA established an Emerging Technology Program to foster dialogue between FDA and manufacturers as they work to develop and implement these approaches.[23] Additionally, a recent workshop at NASEM, and sponsored by the FDA and the Biomedical Advanced Research and Development Authority, focused on the status of, and research opportunities for, continuous manufacturing in the pharmaceutical industry.[24]

Generic Drugs. As previously mentioned, medical product shortages typically involve older, generic products. In January of 2018, the FDA announced a Drug Competition Action Plan aimed at promoting competition and access, especially in the development of generic drugs in pharmaceutical categories that lack competition.[25]

New Companies to Mitigate Drug Shortages

Civica Rx. Recently, more than 120 health organizations have been involved in the creation of a not-for-profit generic drug company, Civica RX, that will manufacture, or sub-contract manufacturing of, critical hospital-administered drugs.[26] Martin VanTrieste, Civica Rx CEO, has stated that "All drug shortages are the result of economics, financial and management decisions." The organization will initially seek to stabilize the supply of essential generic medications administered in hospitals (including sterile injectables), many of which have fallen into chronic shortage situations, putting patients at risk. The organization is focusing on fair and sustainable prices for medications and predicts this initiative will ultimately result in overall lower costs and more predictable supplies of essential generic medicines. Civica Rx expects to have its first products on the market in 2019.

ProvideGx. In January 2019, Premier Inc. announced that it has formed a company intended to help address drug shortages, ProvideGx, and has partnered with five generic drug makers to address a targeted pipeline of 60 crucial drugs that will be available through Premier's GPO.

SUMMARY

The rate of new medical product shortages is increasing and shortages of essential medications are severely impacting patient care and pharmacy operations. The ongoing supply challenges of mostly generic medications, typically injectable products, that are off-patent persist.

A recent FDA data analysis of the scope and scale of drug shortages evaluated the occurrence, duration, intensity, and public health impact medical product shortages.[27] The analysis revealed that the occurrence of active and ongoing shortages is increasing; the duration is longer; shortages are more persistent; intensity is high, as some shortages have been ongoing for >8 years; and the public health impact is high because of an increase in patient harm and health care losses. Congruent with these findings, the FDA has undertaken new initiatives to address the systemic root causes and contributing factors that lead to shortages and determine enduring solutions. Our AMA has been involved in conversations with the FDA and other stakeholders and remains committed to addressing this critical issue. Beyond activity at the federal agency level, the marketplace in 2019 saw the emergence of two new companies, Civica Rx and ProvideGx, which may directly address shortages by bringing into the market supplies of drugs and drug vehicles critically needed by hospitals and the patients they serve.

The AMA's drug shortage policy is timely and already addresses a variety of issues that are under consideration by the FDA and other stakeholder including the improvement quality systems; expedited facility inspections and manufacturing changes/improvements; necessary resiliency and redundancy in manufacturing capability; evaluation of root causes of drug shortages; transparent analysis of economic drivers and reasonable and sustainable payment rates for prescription drugs; greater transparency of the manufacturing process; and including drug manufacturing sites as part of the nation's critical infrastructure plan. Therefore, the Council feels that an update to AMA policy is not warranted at this time.

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Box 1. Resources available to assist in mitigation of drug shortages.

1. ASHP Resource Center
2. ASHP list of current shortages
3. ASHP and University of Utah guidance on small-volume parenteral solutions shortages
4. ASHP and University of Utah guidance on injectable opioid shortages
5. FDA Drug Shortages Page (includes current shortages list, mobile app, and additional information)

APPENDIX 1

AMA Drug Shortage Policy

H-100.956, "National Drug Shortages"

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.

2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages.

12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

APPENDIX 2

ASHP/University of Utah Drug Information Service Drug Shortage Data

Figure 1.

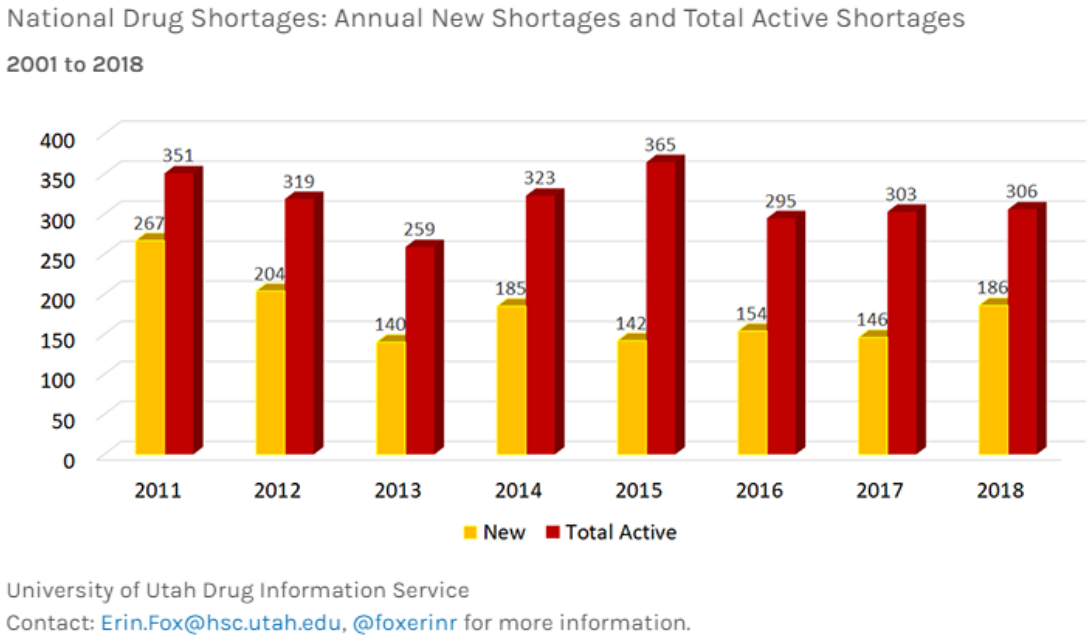


Figure 2.

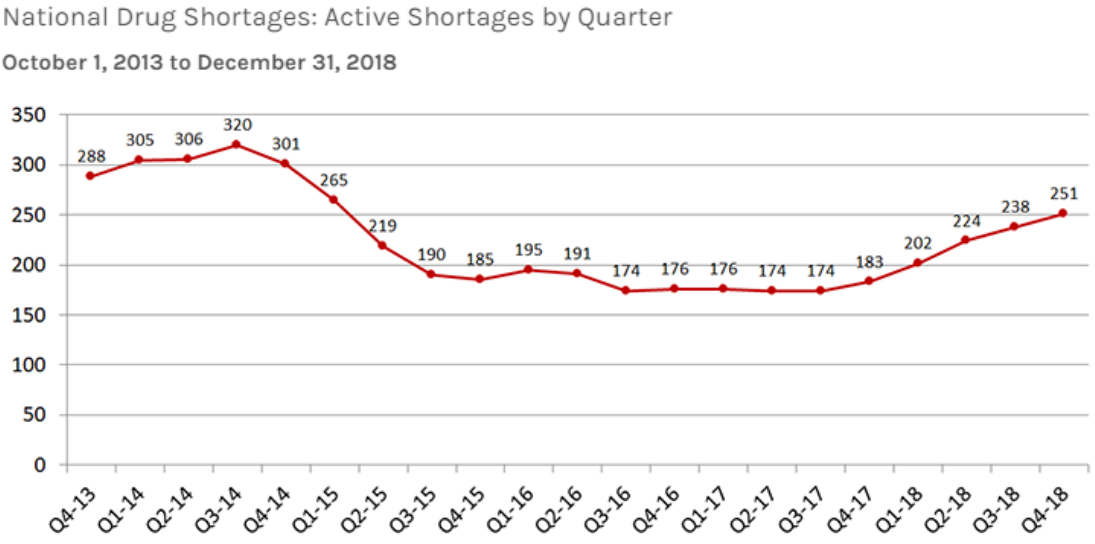
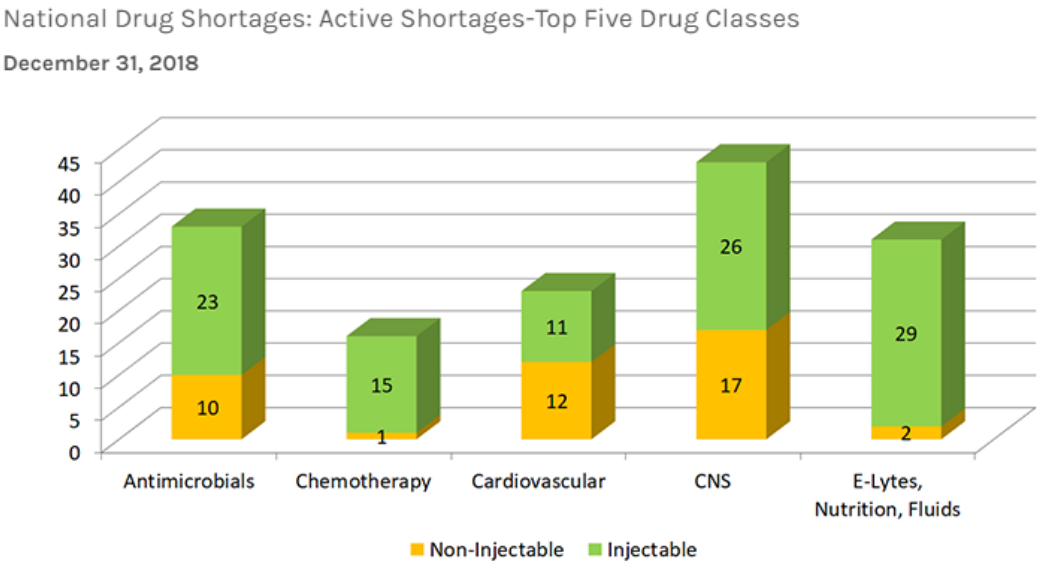
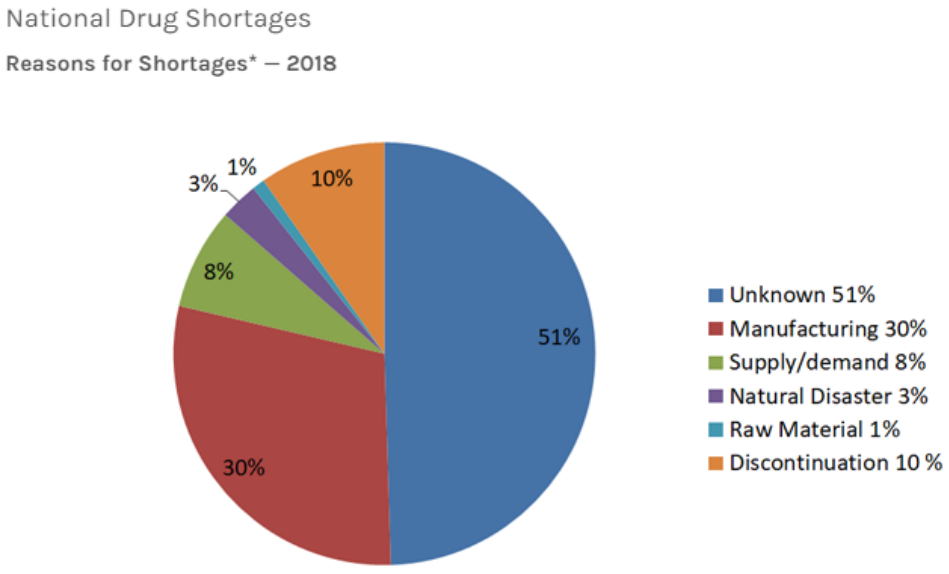


Figure 3.



University of Utah Drug Information Service
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 4.



Based on information provided by manufacturers to the University of Utah Drug Information Service

University of Utah Drug Information Service
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

APPENDIX 3

AMA Comment Letter: Identifying the Root Causes of Drug Shortages and Finding Enduring Solutions; Docket No. FDA-2018-N-3272

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

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January 11, 2019

The Honorable Scott Gottlieb, MD
Commissioner
Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993

Re: Identifying the Root Causes of Drug Shortages and Finding Enduring Solutions; Docket No. FDA-2018-N-3272

Dear Commissioner Gottlieb:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments in response to *Identifying the Root Causes of Drug Shortages and Finding Enduring Solutions.* We applaud the U.S. Food and Drug Administration's (FDA) establishment of a Drug Shortages Task Force in order to identify the root causes of drug shortages and recommend sustainable and structural policy solutions in a report to Congress. The persistence and pervasiveness of drug shortages have consequences for patient care and require an ongoing comprehensive examination of the systemic causes and drivers.

Drug shortages are an urgent public health crisis. Recent shortages have had a negative impact on the delivery and safety of appropriate health care to patients. Long-term shortages have been persistent and critical shortages of basic products such as saline are driving poor patient health outcomes, increasing the potential for medication errors, re-directing scarce administrative and clinical staff time and resources to the identification of alternative treatment options, or delaying patient treatment (such as surgeries). Several commonly used products required for patient care are in shortage, including sterile infusion solutions and injectable products that are off-patent and have few suppliers.[1,2]

To address the drug shortage issue, AMA supports policy, legislation, and/or regulation that:

- Encourages stakeholders in the drug supply chain to increase **collaboration**.
- **Increases transparency** along the pharmaceutical supply chain.
- Establishes plans for **continuity of supply** of vital medications, including the establishment of resiliency and redundancy in manufacturing capability.
- Reduces or **removes regulatory hurdles** and barriers while enhancing flexibilities.
- **Incentivizes investment** in expanded manufacturing production capacity for vital products.

[1] U.S. Government Accountability Office (GAO). Drug Shortages: Certain Factors Are Strongly Associated with This Persistent Public Health Challenge. July 2016.
[2] Mazer-Amirshahi M, Fox ER. Saline Shortages — Many Causes, No Simple Solution. New England Journal of Medicine. 2018; 378:1472-1474

Collaboration

The AMA applauds the FDA's efforts thus far in engaging with a broad range of stakeholders in public meetings and listening sessions and remains committed to participating and assisting. The AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply.[3] We urge stakeholders from the entirety of the drug supply chain and the FDA to work in a collaborative fashion to implement these recommendations.

Increase Transparency

The AMA strongly urges the FDA to require manufacturers to provide greater transparency regarding the drug manufacturing process from start to finish. Knowledge of the entire supply chain, including raw material suppliers, active pharmaceutical ingredient manufacturers and suppliers, distributors and distribution sites, as well as production locations of drugs, can provide the necessary metrics for much-needed quality analysis and information regarding supply chain disruptions that contribute to medical product shortages and their causes. More information about the manufacturing process can inform the causes and anticipated duration of drug shortages and assist in shortage mitigation.

Continuity of Drug Supply

The AMA strongly supports conferring the FDA with enforcement authorities to ensure that drug manufacturers establish a plan for continuity of supply of vital medications and vaccines to avoid production shortages whenever possible. The continuity of supply plan should include the establishment of the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

The AMA strongly supports the designation of drug shortages as a national security priority and the inclusion of vital drug production sites in the critical infrastructure plan. Several manufacturers were impacted by cyber events over the past year and product shortages were worsened by the recent hurricanes impacting Puerto Rico which demonstrate the need to evaluate risk and hazard and disaster response for drug and medical product manufacturing. The AMA urges the application of critical infrastructure policies to the drug shortage challenges clinicians, their patients, and families face each day.

Reduction in Regulatory Burden

The AMA strongly supports the FDA's effort to provide increased flexibilities and engagement when manufacturers have notified the Agency of a potential or actual drug shortage. The AMA continues to specifically support expedited facility inspections and the review of manufacturing changes, drug applications, and supplements that would assist manufacturers in mitigating or preventing a drug shortage. We urge the FDA to consider whether innovative portals, technologies, or collaborations involving big data and augmented intelligence systems (also referred to as artificial intelligence) could be

[3] ASHP Drug Shortages Roundtable Report, November 2018. https://www.ashp.org/drug-shortages/shortage-resources/roundtable-report

deployed by the FDA to forecast potential shortages and root causes including, but not limited, to regulatory policies.

Federal Policies, Market Forces, Investment Incentives

The AMA strongly supports the development of a comprehensive report on the root causes that also analyzes current manufacturing capacity, the number of manufacturers, mergers and consolidations, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. The AMA also urges careful consideration of federal health care program payment rates for drugs that are vulnerable to shortage. The Government Accountability Office identified low profit margins for drugs in shortage as a relevant contributing factor to persistent shortages. Carefully targeted policies to address potential underinvestment in vital products subject to intractable shortages should be evaluated.

The AMA strongly supports collaboration between the Federal Trade Commission (FTC) and the FDA during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers. FTC consultation with the FDA can aid in determining the public health implications of mergers and acquisitions, including the potential impact on drug shortages. Related to the foregoing, the AMA has expressed support for expanded resources and capacity at the FTC to more fully assess and evaluate the impact of mergers and consolidations on competition as well as consumer access as part of the FTC's charge to advance consumer protection. Without oversight and intervention, drug shortages will exist into the foreseeable future if further consolidations occur reducing production capacity.

Our physician members and their patients are negatively impacted by the persistent and ongoing shortages of necessary and often basic medical products. We look forward to working closely with you and other federal agencies to take rapid, direct action where opportunity exists to permanently resolve or mitigate drug shortages. If you have questions, please contact Shannon Curtis, Assistant Director, Division of Federal Affairs at shannon.curtis@ama-assn.org or 202-789-8510.

Sincerely,

James L. Madara, MD

REPORT OF THE SPEAKERS

Speakers' Report A-19

Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, Speaker; and Bruce A. Scott, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to deal with policies, or portions of policies, that are no longer relevant or that were affected by actions taken at the recent meetings of the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action. Where changes to policy language will be made, additions are shown with underscore and deletions are shown with strikethrough.

RECOMMENDED RECONCILIATIONS

Policies to be rescinded in their entirety

The following directives will be rescinded in full, as the requested activity has been completed, with reports presented to the House of Delegates when required.

- D-615.978, "Creation of LGBTQ Health Specialty Section Council" (to be rescinded)
  Our AMA will establish a Specialty Section Council on LGBTQ Health.

  This directive can be rescinded as the action has been accomplished. The glossary to the AMA Bylaws along with other documents, such as website and HOD Reference Manual note the newly established Specialty Section Council on LGBTQ Health.

- D-620.988, "Analysis of American Board of Internal Medicine (ABIM) Finances" (to be rescinded)
  1. Our AMA, prior to the end of December 2016, will formally, directly and openly ask the American Board of Internal Medicine (ABIM) if they would allow an independent outside organization, representing ABIM physician stakeholders, to independently conduct an open audit of the finances of both the American Board of Internal Medicine (ABIM), a 501(c)(3) tax-exempt, non-profit organization, and its Foundation.
  2. In its request, our AMA will seek a formal and rapid reply from the ABIM so that issues of concern that currently exist between the ABIM and its Foundation and many members of the AMA and the physician community at large can be addressed in a timely, effective and efficient fashion.
  3. Our AMA will share the response to this request, as well as the results of any subsequent analysis, with our AMA House of Delegates and our membership at large as soon as it is available.
  4. Our AMA will call on the American Board of Medical Specialties and its component specialty boards to provide the physicians of America with financial transparency,

independent financial audits and enhanced mechanisms for communication with and feedback from their diplomate physicians.

This directive was acted on in December 2016, immediately after the policy was adopted at the 2016 Interim Meeting. The American Board of Internal Medicine's verbatim responses to the questions were shared with the House in an email from your Speakers on January 23, 2017.

Policy H-515.975, "Alcohol, Drugs, and Family Violence" has been incorporated word for word into Policy H-515.965, "Family and Intimate Partner Violence," and is therefore redundant. The former will be rescinded, the latter retained.

- H-515.975, "Alcohol, Drugs, and Family Violence" (to be rescinded)
  Given the association between alcohol and family violence, physicians should be alert to look for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse, should screen for alcohol use. (2) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (3) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

  H-515.965, "Family and Intimate Partner Violence" (to be retained)
  …
  (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.

Policies dealing with the AMA-convened Physician Consortium for Performance Improvement® (AMA-PCPI®)

Several policies deal with the AMA-PCPI which was initially established as a program of the AMA. The AMA-PCPI ceased all activities upon activation of an independent 501(c)(3) organization, the PCPI Foundation® (PCPI®). Consequently, some policies should be rescinded and others amended to clarify these changes and our AMA's role in the successor organization. Policies D-450.983 and D-478.974 should be rescinded as they no longer accurately reflect our AMA's roles and responsibilities. The latter policy also references activity that was concluded years ago.

- D-450.983, "Expansion of Scope of Activities of AMA Physician Consortium for Performance Improvement" (to be rescinded)
  Our AMA will:
  (1) expand the AMA Physician Consortium for Performance Improvement (Consortium) to include representatives from all national medical specialty societies and state medical societies who wish to participate;
  (2) expand the scope of the Consortium to include development of clinical performance measures, validation of clinical performance measures, and direction on appropriate implementation of clinical performance measures;
  (3) study and prepare a report to clarify the role and authority of the National Quality Forum and identify pathways that may allow the Consortium and physicians to have greater influence in the validation of clinical performance measures;
  (4) continue to advocate for the AMA-convened Physician Consortium for Performance Improvement (PCPI) as a leading measure development organization that addresses measures of underuse, overuse, and appropriateness;
  (5) continue to engage with the national medical specialty society members of the PCPI to identify topics to expand the PCPI portfolio of quality measures addressing, in particular, overuse and appropriateness;
  (6) engage national medical specialty societies who are leaders with the PCPI in developing measures of overuse and appropriateness to submit editorials and distribute society member communications announcing the availability and importance of these measures developed by the profession;
  (7) continue to seek opportunities to align measures of quality with measures of cost; and
  (8) ensure that the PCPI provides opportunities for active involvement by all affected specialties in the measure development and approval process.

- D-478.974, "Quality Improvement in Clinical / Population Health Information Systems" (to be rescinded)
  Our American Medical Association will invite other expert physician associations into the AMA consortium to further the quality improvement of electronic health records and population health as discussed in the consortium letter of January 21, 2015 to the National Coordinator of Health Information Technology.

Obsolete references to be deleted from PCPI-related policies

The following two policies require minor changes to reflect our AMA's role in PCPI as well as the organization's name. Other, more substantive changes to the policies would need to be addressed through other vehicles. Renumbering of paragraphs will be accomplished as necessary. Only the relevant portion of Policy H-406.990 is quoted below.

- H-406.990, "Work of the Task Force on the Release of Physician Data"
  Release of Claims and Payment Data from Governmental Programs

  The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.
  …
  (c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:

(i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties~~, such as the PCPI AMA-convened Physician Consortium for Performance Improvement~~….

- D-450.978, "PCPI ~~Physician Consortium for Performance Improvement~~; Unfunded Performance Improvement Projects"
  Our AMA will:
  (1) ~~continue to expand the Physician Consortium for Performance Improvement (Consortium), inviting all medical societies in the AMA House of Delegates to participate;~~
  (2) continue to promote the PCPI® ~~Consortium~~ as the leading resource for performance measures development and maintenance;
  (3) continue to advocate for appropriate implementation of performance measures;
  (4) continue to encourage the testing and evaluation of PCPI ~~Consortium~~ measures by appropriate entities;
  (5) continue to communicate organized medicine's strong objections to implementation of mandatory, unfunded performance improvement projects and offer our assistance to rectify deficiencies in these programs;
  (6) continue to promote the AMA guidelines that provide operational boundaries that can be applied to specific components of pay-for-performance programs; and
  (7) monitor the ~~newly established~~ National Quality Forum, a merger of the National Quality Forum and the National Committee for Quality Health Care, to determine its current and future scope.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.

Fiscal Note: $250