

Memo to: Delegates, Alternate Delegates
Executive Directors, Member Organizations of the House of Delegates

From: Susan R. Bailey, MD, Speaker, House of Delegates
Bruce A. Scott, MD, Vice Speaker, House of Delegates

Date: May 17, 2019

Subject: Handbook Addendum - Supplemental Business and Information (A-19)

We are pleased to provide the attached report and resolutions that were received after the Delegates' Handbook resolution deadline:

- Report of the HOD Committee on Compensation of the Officers (Reference Committee F)

Resolutions

- 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
- 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

- 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
- 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
- 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
- 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
- 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
- 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
- 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

Each of these items also appears in the online member forum (ama-assn.org/forums/house-delegates, login required). Additional items will be posted there as they are processed for the Sunday tote.

The charts listing actions taken in follow-up to resolutions and report recommendations from the 2018 Annual and Interim Meetings will be posted on the Annual Meeting website (ama-assn.org/annual-meeting).

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.

1 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
2 with that of all other Officers (excluding Presidents and Chair) because these positions perform
3 comparable work.

4
5 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
6 Group, to update his 2007 research by providing the Committee with comprehensive advice and
7 counsel on Officer compensation. The updated compensation structure was presented and approved
8 by the HOD at I-11 with an effective date of July 1, 2012.

9
10 The Committee's I-13 report recommended and the HOD approved the Committee's
11 recommendation to provide a travel allowance for each President to be used for upgrades because
12 of the significant volume of travel in representing our AMA.

13
14 At I-16, based on the result of a comprehensive compensation review conducted by Ms. Becky
15 Glantz Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee
16 recommended and the HOD approved modest increased to the Governance Honorarium and Per
17 Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
18 17's report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
19 so that Internal Representation, in excess of eleven days, receives a per diem.

20
21 At A-18, based on a compensation review focused on the Presidents' and Chairs' compensation,
22 the Committee recommended and the House approved a modest increase to their Honoraria, the
23 first increase in ten years.

24 25 METHODOLOGY

26
27 At I-18, this Committee recommended and the House approved an Annual Health Insurance
28 Stipend (Stipend) for the President, President-Elect and the Immediate Past President when
29 replacement health insurance is needed because he/she loses health insurance coverage at their
30 practice, university or hospital (collectively referred to as "Employer") when they reduce their
31 work schedule to fulfill their responsibilities as President, President-Elect or Immediate Past
32 President.

33
34 The amount of the Stipend was based on 70% of the then current Gold Plan premium in the
35 President(s) state of residence for each covered family member. The Stipend ended when a
36 President, President-Elect or Immediate Past President became Medicare eligible during their term
37 in office because the Stipend was based on the President's need for health insurance which was met
38 via Medicare.

39
40 The Committee heard testimony at Reference Committee F in support of the Stipend, however
41 there were questions about the Stipend ending for the President's covered family members when
42 the President became Medicare eligible while in office. The Committee completed additional
43 research and concluded that revisions to the definitions were warranted because the President(s)
44 covered family members also needed replacement health insurance when the President(s) lost
45 insurance from his/her Employer upon reducing their work schedule to fulfill AMA
46 responsibilities.

47
48 The Committee also noted that for clarity, the definition of the Stipend replaces "age 65" with
49 "Medicare eligibility."

1 FINDINGS

2
3 The Committee notes that the President-Elect, President and Immediate Past President
4 responsibilities require a significant time commitment in supporting our AMA in governance and
5 representation functions. Our A-18 report noted that this level of responsibility results in a time
6 commitment well above that required by other not-for-profit boards. The level of commitment
7 needed in supporting our AMA may necessitate a President reduce his/her work schedule with
8 his/her Employer to a part-time status which may result in a President and his/her covered family
9 members losing their eligibility for Employer's health insurance coverage.

10
11 This Committee considers health insurance a necessity. At I-18 the Committee recommended and
12 the House approved a Stipend for the President and his/her family when they lose their Employer's
13 health insurance. This Committee recommends amending the definition of eligibility so that
14 President(s) who already have health insurance coverage through Medicare when elected will not
15 be eligible for the Stipend for themselves or family members. Additionally, this Committee
16 recommends amending the eligibility definition so that if a President becomes Medicare eligible
17 while in office, the President will be expected to enroll in Medicare and the Stipend will continue
18 to cover family members who are not Medicare eligible. The amount of the Stipend will be
19 adjusted accordingly. The Stipend would be reported as taxable income to the President(s).

20
21 RECOMMENDATIONS

22
23 The Committee on Compensation of the Officers recommends the following recommendations be
24 adopted and the remainder of this report filed:

- 25
26 1. That Policy D-605.990 be appended by a new section XXIII as follows:

27
28 Annual Health Insurance Stipend ("Stipend")

29 The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate
30 the President, President-Elect, and Immediate Past President when the President(s) lose(s)
31 his/her Employer provided medical insurance coverage. President(s) who lose his/her
32 Employer insurance will substantiate his/her eligibility for the Stipend by written notice to the
33 Board Chair detailing the effective date of the loss of coverage and listing covered family
34 members. The President receiving the Stipend will have the sole discretion to determine the
35 appropriate health insurance for himself/herself and the family members; however, the Stipend
36 will be calculated based on 70% of the then current Gold Plan premium for his/her state/county
37 of residence.

38
39 Should a President become Medicare eligible during his/her term(s), the Stipend will end for
40 the President the month Medicare coverage begins. If the President has covered family
41 members who are not Medicare eligible, the amount of the Stipend will be adjusted to cover
42 only those family members until they become Medicare eligible. As family members become
43 Medicare eligible, the President is expected to provide written notice of the event to the Board
44 Chair and the Stipend will be adjusted accordingly the month Medicare coverage begins.

45
46 In any case, the Stipend will end the sooner the President(s) obtains other health insurance
47 coverage or the month following the end of his/her term as Immediate Past President.

48
49 Should a President have health insurance coverage through Medicare when elected, he/she will
50 not be eligible for the Stipend for themselves or family members.

1 The amount of the Stipend will be 70% of the then current Gold Plan premium in the
2 President(s) state/county of residence for each covered family member. If there are multiple
3 Gold Plans in the state/county, the Stipend will be based on the average of the then current
4 Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year
5 based on then Gold Plan premiums and covered family members.

6
7 The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable
8 income for the President each calendar year and will be included in this Committee's annual
9 report to the House which documents compensation paid to Officers and the IRS reported
10 taxable value of benefits, perquisites, services, and in-kind payments.

- 11
12 2. Except as noted above, there will be no other changes to the Officers compensation for the
13 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: 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

1 Whereas, The Federal Bureau of Investigation reported a 17% increase in hate crime reports in
2 2017 compared to 2016 data, a rise for the third consecutive year;¹² and

3
4 Whereas, Of the more than 7,100 hate crimes reported in 2017, the Federal Bureau of
5 Investigation concluded nearly three out of five were motivated by race and ethnicity; and

6
7 Whereas, Numerous studies have found that transgender people, especially transgender people
8 of color, face high rates of sexual assault, intimate partner violence, and other non-fatal
9 violence; and

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

16
17 Whereas, The physical risks faced by transgender individuals can have long and short-term
18 negative impacts on the physical and mental health of these individuals, survivors, their
19 communities, and the nation as a whole; therefore be it

20
21 RESOLVED, That our American Medical Association partner with other medical organizations
22 and stakeholders to immediately increase efforts to educate the general public, legislators, and
23 members of law enforcement using verified data related to the hate crimes against transgender
24 individuals highlighting the disproportionate number of Black transgender women who have
25 succumbed to violent deaths (Directive to Take Action); and be it further

26
27 RESOLVED, That our AMA advocate for federal, state, and local law enforcement agencies to
28 consistently collect and report data on hate crimes, including victim demographics, to the FBI;
29 for the federal government to provide incentives for such reporting; and for demographic data on
30 an individual's birth sex and gender identity be incorporated into the National Crime
31 Victimization Survey and the National Violent Death Reporting System, in order to quickly
32 identify positive and negative trends so resources may be appropriately disseminated (Directive
33 to Take Action); and be it further

34
35 RESOLVED, That our AMA advocate for a central law enforcement database to collect data
36 about reported hate crimes that correctly identifies an individual's birth sex and gender identity,
37 in order to quickly identify positive and negative trends so resources may be appropriately
38 disseminated (Directive to Take Action); and be it further

39
40 RESOLVED, That our AMA advocate for stronger law enforcement policies regarding
41 interactions with transgender individuals to prevent bias and mistreatment and increase
42 community trust (Directive to Take Action); and be it further

43
44 RESOLVED, That our AMA advocate for local, state, and federal efforts that will increase
45 access to mental health treatment and that will develop models designed to address the health
46 disparities that LGBTQ individuals experience (Directive to Take Action); and be it further

47
48 RESOLVED, That our AMA issue a press release following the conclusion of the annual House
49 of Delegates meeting with updates to be published in both scientific and mainstream
50 publications regarding the prevalence of physical and mental health conditions and barriers
51 faced by the LGBTQ community. (Directive to Take Action)

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

Received: 05/09/19

References:

1. Ramirez JL, Gonzalez KA, Galupo MP. "Invisible During My Own Crisis": Responses of LGBT People of Color to the Orlando Shooting. *J Homosex* 2018;65:579-99.
2. Schneeberger AR, Dietl MF, Muenzenmaier KH, Huber CG, Lang UE. Stressful childhood experiences and health outcomes in sexual minority populations: a systematic review. *Soc Psychiatry Psychiatr Epidemiol* 2014;49:1427-45.
3. Hightow-Weidman LB, Phillips G, 2nd, Jones KC, et al. Racial and sexual identity-related maltreatment among minority YMSM: prevalence, perceptions, and the association with emotional distress. *AIDS Patient Care STDS* 2011;25 Suppl 1:S39-45.
4. Brumbaugh-Johnson SM, Hull KE. Coming Out as Transgender: Navigating the Social Implications of a Transgender Identity. *J Homosex* 2018:1-30.
5. Rood BA, Reisner SL, Surace FI, Puckett JA, Maroney MR, Pantalone DW. Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals. *Transgend Health* 2016;1:151-64.
6. Winter S, Diamond M, Green J, et al. Transgender people: health at the margins of society. *Lancet* 2016.
7. Schuster MA, Reisner SL, Onorato SE. Beyond Bathrooms--Meeting the Health Needs of Transgender People. *N Engl J Med* 2016;375:101-3.
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10. Crenshaw K. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review* 1991;43:1241-99.
11. Human Rights Campaign. A National Epidemic: Fatal Anti-Transgender Violence in America in 2018. 2019.
12. Hate Crimes. 2019. at <https://www.fbi.gov/investigate/civil-rights/hate-crimes>.
13. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi, M. The Report of the 2015 U.S. Transgender Survey. 2016.

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)

1 Whereas, The concept of protection against discrimination or harassment is not controversial,
2 however, generally accepted, standard language for protected classes or groups does not exist
3 among national organizations; and
4

5 Whereas, American Medical Association policy (and therefore Policy Finder) has multiple,
6 inconsistent references with variable language regarding protection against discrimination or
7 harassment against populations; therefore be it
8

9 RESOLVED, That our American Medical Association undertake a study to identify all
10 discrimination and harassment references in AMA policies and the code of ethics, noting when
11 the language is consistent and when it is not (Directive to Take Action); and be it further
12

13 RESOLVED, That our AMA research language and terms used by other national organizations
14 and the federal government in their policies on discrimination and harassment (Directive to Take
15 Action); and be it further
16

17 RESOLVED, That our AMA present the preliminary study results the Minority Affairs Section,
18 the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach
19 consensus on optimal language to protect vulnerable populations including racial and ethnic
20 minorities, sexual and gender minorities, and women, from discrimination and harassment
21 (Directive to Take Action); and be it further
22

23 RESOLVED, That our American Medical Association produce a report within 18 months with
24 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)

1 Whereas, Covenants not to compete have been used to force physicians to leave communities
2 if they leave hospital employment; and
3

4 Whereas, Recruiting and promoting new partners, building their referral bases, and purchasing
5 necessary equipment is a significantly expensive undertaking; and
6

7 Whereas, Practices endure significant financial harm when a hospital can lure a partner away,
8 and a requirement to pay liquidated damages when that happens mitigates the financial harm
9 without requiring the partner to leave the community; and
10

11 Whereas, New Mexico passed a statute that prohibits covenants not to compete for employed
12 physicians but allows for liquidated damages to be paid when a partner who is a part owner in a
13 practice is lured away by a competing hospital system; and
14

15 Whereas, The New Mexico statute is a model that could be used by the AMA Council on
16 Legislation as an example for other states; and
17

18 Whereas, The AMA Council on Ethical and Judicial Affairs opposes covenants not to compete in
19 all circumstances; therefore be it
20

21 RESOLVED, That our American Medical Association consider as the basis for model legislation
22 the New Mexico statute allowing a requirement that liquidated damages be paid when a
23 physician partner who is a part owner in practice is lured away by a competing hospital system
24 (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA ask our Council on Ethical and Judicial Affairs to reconsider their
27 blanket opposition to covenants not to compete in the case of a physician partner who is a part
28 owner of a practice, in light of the protection that liquidated damages can confer to independent
29 physician owned partnerships, and because a requirement to pay liquidated damages does not
30 preclude a physician from continuing to practice in his or her community. (Directive to Take
31 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)

1 Whereas, Vaccines have been one of the most effective methods of infectious disease control in
2 the past century, preventing 732,000 premature deaths in children born in the United States
3 between 1994 and 2013; and
4

5 Whereas, One of the goals of Healthy People 2020 is to increase immunization rates, targeting
6 a reduction in the incidence of 17 vaccine-preventable diseases in the United States; and
7

8 Whereas, There have been several recent well-publicized outbreaks of vaccine-preventable
9 illnesses such as measles, mumps, and pertussis in the United States, including the 2018
10 Michigan measles outbreak; and
11

12 Whereas, The prevalence of unvaccinated pediatric patients is rising in the United States, and
13 many children are unvaccinated due to parental distrust of vaccines; and
14

15 Whereas, Despite legislative efforts to regulate opt-out waivers for vaccinations, the Michigan
16 immunization waiver rate remains higher than three percent for both kindergarten and eighth
17 grade students, with greater than 70 percent of those waivers for philosophical rather than
18 religious or medical reasons; and
19

20 Whereas, A 2018 study found that three of the nation's 14 metropolitan "hotspots" for non-
21 medical exemption from vaccination are located in Michigan--Troy, Warren, and Detroit--
22 demonstrating a high risk of vaccine-preventable disease outbreaks; and
23

24 Whereas, Declining vaccination rates increase the probability of outbreaks of vaccine-
25 preventable diseases, and states with more opportunities for vaccination exemption have more
26 measles outbreaks; and
27

28 Whereas, Unvaccinated adolescents report interest in receiving vaccines to prevent against
29 common childhood illnesses; and
30

31 Whereas, Federal law does not require parental consent for vaccinations and many states,
32 including Michigan, do not have comprehensive statutes surrounding vaccination policy; and
33

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

1 Whereas, Adolescents in 21 states do not require parental consent for treatment of reportable
2 diseases, which include hepatitis B, measles, mumps, and pertussis; and
3

4 Whereas, The inability for minors to provide consent to vaccinations has been cited as a barrier
5 to vaccination rates; and
6

7 Whereas, An American Academy of Pediatrics' article proposed minor consent to vaccination
8 via the mature minor doctrine, a widely accepted legal concept allowing "certain older minors
9 who have the capacity to give informed consent to do so for care that is within the mainstream
10 of medical practice, not high risk, and provided in a non-negligent manner;" and
11

12 Whereas, Vaccinations are safe, effective, low-risk, and necessary for a multi-faceted,
13 comprehensive approach to public health and it is thus in the interest of the medical community
14 and concerned citizens to promote access to vaccination; and
15

16 Whereas, Allowing mature minors an avenue to provide for their own personal health, when
17 they have no medical contraindications to the vaccinations and are given the same
18 comprehensive vaccine information as consenting adults, abides by the same ethical standards
19 as other procedures allowed for in Michigan without parental consent; therefore be it
20

21 RESOLVED, That our American Medical Association amend the policy H-440.830, "Education
22 and Public Awareness on Vaccine Safety and Efficacy," by addition and deletion as follows:
23

24 Our AMA (a) encourages the development and dissemination of evidence-based
25 public awareness campaigns aimed at increasing vaccination rates; (b) encourages
26 the development of educational materials that can be distributed to patients and their
27 families clearly articulating the benefits of immunizations and highlighting the
28 exemplary safety record of vaccines; (c) supports the development and evaluation, in
29 collaboration with health care providers, of evidence-based educational resources to
30 assist parents in educating and encouraging other parents who may be reluctant to
31 vaccinate their children; (d) encourages physicians and state and local medical
32 associations to work with public health officials to inform those who object to
33 immunizations about the benefits of vaccinations and the risks to their own health and
34 that of the general public if they refuse to accept them; (e) will promote the safety and
35 efficacy of vaccines while rejecting claims that have no foundation in science; ~~and~~
36 (f) supports state policies allowing adolescents to provide their own consent for
37 vaccination and encourages state legislatures to establish comprehensive vaccine and
38 minor consent policies; and (g) will continue its ongoing efforts with other immunization
39 advocacy organizations to assist physicians and other health care professionals in
40 effectively communicating to patients, parents, policy makers, and the media that
41 vaccines do not cause autism and that decreasing immunization rates have resulted in
42 a resurgence of vaccine-preventable diseases and deaths. (Modify Current HOD
43 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)

1 Whereas, Body donation is essential to medical-surgical education, continuing education
2 programs, clinical practice, and research, even as new virtual technology emerges¹⁻¹⁷; and
3

4 Whereas, Research and education conducted on donated bodies is beneficial to patients,
5 society, and the medical profession^{14,17,18,19,20,21}; and
6

7 Whereas, Body donation, transplant tissue donation, and vascular organ donation are all
8 examples of how an individual person may donate part or all of his or her body to the institutions
9 of science and medicine^{22,23,24}; and
10

11 Whereas, Transplant tissue and vascular organ donations are heavily regulated on a federal
12 level by the Food and Drug Administration (FDA) and the Health Resources Service
13 Administration (HRSA), respectively^{25,26,27}; and
14

15 Whereas, Body donation is classified as neither transplant tissue donation nor vascular organ
16 donation and is thus not regulated by either the FDA or HRSA, creating a gap in federal
17 oversight and resulting in state- and institutional-level regulation^{16,29,30}; and
18

19 Whereas, As a result, body donation practices lack transparency and consistency, creating
20 loopholes between federal, state, and institutional policy^{16,29,30,31,32}; and
21

22 Whereas, The lack of consistent and appropriate monitoring of bodies and body parts results in
23 lost tissues and incorrectly returned remains^{30,33}; and
24

25 Whereas, Lack of regulation allows for market incentives to drive unethical body part
26 acquisitions, requiring each individual institution, research team, and health care provider to set
27 their own ethical bar^{30,31,32}; and
28

29 Whereas, Lack of regulation allows misleading marketing that focuses on financial incentives
30 (e.g., free cremation) and does not clearly explain how donated bodies are used, which leads to
31 an incongruence between donor/family wishes and understanding, and the resulting use of their
32 bodies^{29,32,34}; and
33

34 Whereas, The AMA supports federal oversight for processes involving tissue and organ
35 donation to the medical profession through existing Policy (H-370.988); and
36

37 Whereas, The AMA Code of Ethics has established importance of removing potential financial
38 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 regulation³⁶; 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)

1 Whereas, In 2017 it became policy that unaccompanied immigrant minors – children that enter
2 the United States in family units and those that cross individually – must be placed under the
3 custody of Office Refugee Resettlement (ORR) of the Department of Health and Human
4 Services (HHS) ¹; and

5
6 Whereas, In 2017, 40,810 unaccompanied immigrant children were referred to ORR, where the
7 average length of stay was 41 days²; and

8
9 Whereas, Children in ORR custody frequently receive medical and mental health services
10 during their detainment³; and

11
12 Whereas, Confidential medical and psychological records and social work case files from ORR
13 are increasingly presented in immigration court as evidence for deportation or further
14 detainment^{4,5}; and

15
16 Whereas, Before a child reaches the age of 18 they cannot exercise their own HIPAA rights
17 without the signature of a parent or guardian, and children in detainment are separated from
18 their parents, and therefore do not have access to their own HIPAA rights⁶⁻⁷; and

19
20 Whereas, Breaches in patient confidentiality, or the perceived threat thereof, create distrust in
21 the healthcare system and lead to patients delaying or forgoing medical care, particularly in
22 immigrant populations⁸⁻¹⁰; and

23
24 Whereas, Undocumented children forcibly separated from parents at the US border
25 have been shown to be at increased risk for post-traumatic stress disorder, anxiety, depression,
26 aggression and suicidal ideation^{11,12}; and

27
28 Whereas, Separating children from their parents during development has been linked with later
29 risk of criminality and mental health issues such as bipolar disorder and schizophrenia¹³; and

30
31 Whereas, Existing AMA policy calls for our AMA to “work with medical societies and all
32 clinicians to work together with other child-serving sectors to ensure that new immigrant children
33 receive timely and age-appropriate services that support their health and well-being” (D-60.968);
34 and

35
36 Whereas, Existing AMA policy directs our AMA to “recommend the U.S. Immigrations and
37 Customs Enforcement refrain from partnerships with private institutions whose facilities do not

1 meet the standards of medical, mental, and dental care as guided by the National Commission
2 on Correctional Health Care” (D-350.983); and
3

4 Whereas, Existing AMA policy instructs our AMA to “support protections that prohibit... law
5 enforcement agencies from utilizing information from medical records to pursue immigration
6 enforcement actions against patients who are undocumented” (H-315.966); therefore be it
7

8 RESOLVED, That our American Medical Association advocate that healthcare services
9 provided to minors in immigrant detention focus solely on the health and well-being of the
10 children (Directive to Take Action); and be it further
11

12 RESOLVED, That our AMA condemn the use of confidential medical and psychological records
13 and social work case files as evidence in immigration courts without patient consent. (Directive
14 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 health¹; and

Whereas, Patient advocacy groups provide education, outreach, and support services to patients affected by a medical condition²; 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 inconsistent⁴; 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 interest⁴; 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 benefits²; 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 ties⁷; 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 2010⁴; 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 practices⁵; 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 delivered such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

- (a) Are transparent.
- (b) Reflect input from key stakeholders, including physicians and patients.
- (c) Recognize that over reliance on financial incentives may undermine physician professionalism.
- (d) Ensure ethically acceptable incentives that:
 - (i) are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;

- (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
 - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
 - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
 - (e) Encourage, rather than discourage, physicians (and others) to:
 - (i) provide care for patients with difficult to manage medical conditions;
 - (ii) practice at their full capacity, but not beyond.
 - (f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
 - (g) Are routinely monitored to:
 - (i) identify and address adverse consequences;
 - (ii) identify and encourage dissemination of positive outcomes.
- All physicians should:
- (h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
 - (i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

[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 physician treatment 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 biasing or being perceived to bias - professional judgment in the care of patients.

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

- (a) Decline cash gifts in any amount from an entity that has a direct interest in physician treatment recommendations.
- (b) Decline any gifts for which reciprocity is expected or implied.
- (c) Accept an in-kind gift for the physician's practice only when the gift:
 - (i) will directly benefit patients, including patient education; and
 - (ii) is of minimal value.
- (d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:
 - (i) the program identifies recipients based on independent institutional criteria; and
 - (ii) funds are distributed to recipients without specific attribution to sponsors.

[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 birth¹; 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 nonconforming²; 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 compelled³⁻⁵; 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 patients⁶; 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 programs⁸; 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 identity¹³; 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 intercourse¹⁴; and

Whereas, Sixty-one percent of LGBTQ+ youth report being open about their sexual orientation and/or gender identity at school¹⁵; 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 unnecessarily¹⁵; 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)

1 Whereas, In the United States, approximately eight million adults identify as lesbian, gay, or
2 bisexual, and 700,000 adults identify as transgender¹; and
3

4 Whereas, In 2016, the National Institute of Minority Health and Health Disparities, part of the
5 National Institutes of Health (NIH), designated sexual and gender minorities (SGM) as a health
6 disparity population for research purposes²; and
7

8 Whereas, In 2015, the NIH established a Sexual and Gender Minority Research Office that
9 provides funding earmarked for SGM-specific medical research^{3,4}; and
10

11 Whereas, There continues to be a paucity of research regarding health care issues and
12 integrated care interventions affecting lesbian, gay, bisexual, and transgender (LGBT)-identified
13 youth and older adults⁵⁻⁷; and
14

15 Whereas, Investigators failing to collect sexual preference data on study participants has been
16 identified as a barrier to detecting health trends among SGM populations⁸; and
17

18 Whereas, Despite the relative scarcity of studies that record SGM identifiers, research has
19 shown significant disparities between SGM groups and between those populations and the
20 general public, such as modifiable risk factors for cardiovascular disease, prevalence and
21 predictors of obesity, mental health and substance use disorders, sexually transmitted
22 infections, and suicidal ideation and suicidality⁹⁻¹⁶; and
23

24 Whereas, The U.S. Department of Health and Human Services' Office of Disease Prevention
25 and Health Promotion, as a part of the Healthy People 2020 initiative, set a goal of increasing
26 the number of states that include questions identifying sexual orientation and gender identity on
27 state level surveys and/or data systems¹⁷; and
28

29 Whereas, Collecting data on patients' sexual orientation and gender identity in the electronic
30 health record is supported by multiple sources, including the National Academy of Medicine's
31 2011 report on LGBT health, Healthy People 2020, the Affordable Care Act, and the Joint
32 Commission¹⁸; and
33

34 Whereas, Pursuant to existing AMA policy H-460.909, our AMA believes research priorities and
35 methodology should factor in any systematic variations in disease prevalence or response
36 across groups by race, ethnicity, gender, age, geography, and economic status; and
37

38 Whereas, Pursuant to existing AMA policy H-460.907, our AMA encourages research into
39 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)

1 Whereas, Guardianship is defined as a legal relationship created when a state court grants a
2 person or entity the authority to make decisions on behalf of an incapacitated individual
3 concerning his/her person or property^{1,2}; and
4

5 Whereas, Incapacity is defined as the inability “to meet essential requirement for physical
6 health, safety, and self-care even with appropriate technological assistance” (functional
7 incapacity) or the inability to “receive and evaluate information or make or communicate
8 decisions” (cognitive incapacity)^{3,4}; and
9

10 Whereas, A guardian is expected to direct an individual’s assets and benefits towards “food,
11 clothing, housing, medical care, personal items, and other immediate and reasonably
12 foreseeable needs”²; and
13

14 Whereas, Approximately 1.5 million adults in the U.S. are under the care of guardians⁵⁻⁷; and
15

16 Whereas, The U.S. Census Bureau estimated within the U.S. there were over 46 million
17 individuals aged 65 and older (2014) and that figure would double by year 2050¹; and
18

19 Whereas, Given the combined anticipated growth of the geriatric population and the prevalence
20 of neurodegenerative diseases, more comprehensive guardianship programs and standard
21 state-level guidelines are warranted to ensure continued delivery of quality care^{8,9}; and
22

23 Whereas, Guardianship programs are overseen by individual states’ laws, regulations, and court
24 systems and there is currently no nationwide system of guardianship in place^{1,2,10-13}; and
25

26 Whereas, In September 2016, only 12 states required certification of professional guardians
27 (who may range from family, friends, corporate professionals, or government officials), and in
28 many states, guardians are not required to receive any formal training^{6,14}; and
29

30 Whereas, In 2011, the Government Accountability Office (GAO) determined there was
31 widespread failure of guardians to faithfully execute their court-ordered duties including through
32 neglect, abuse, and financial exploitation, inadequate screening and training of, and insufficient
33 oversight of guardians after appointment^{2,15}; and
34

35 Whereas, Oversight and evaluation of guardians is often minimal, and courts and public
36 systems are commonly underfunded and understaffed which results in great difficulty enforcing
37 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 expenses¹³; 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 patients' well-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 normal families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
 - (e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
 - (f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
 - (g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
 - (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 patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
 - (h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
- Collectively, physicians should:
- (i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.

(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.

(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.

(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.

(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.

[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)

1 Whereas, Around 670,000 children in the U.S will spend time in foster care in any given year,
2 and the number of children in foster care has been increasing since 2012¹⁻⁴; and
3

4 Whereas, Children in foster care are one of the most vulnerable populations, often suffering
5 from a higher likelihood of early adverse childhood experiences and disproportionately affected
6 by lack of appropriate housing, behavioral problems, and the disparities associated with minority
7 populations^{2,8-10};
8

9 Whereas, A series of highly-publicized episodes of abuse, neglect, and child deaths in the for-
10 profit foster care system prompted the Senate Finance Committee to conduct an investigation
11 into the privatization of foster care services, and the Committee published a report of their
12 findings in 2017^{3,5,6}; and
13

14 Whereas, The Senate Finance Committee report found that children in the foster care system
15 die at an alarmingly high rate that is 42% higher than the national death rate for children with
16 similar health conditions and risk factors, and 70% of these deaths were unexpected^{3,7}; and
17

18 Whereas, These deaths were often found to have occurred in cases in which children had been
19 placed with foster parents who had a record of abuse;^{3,5} and
20

21 Whereas, In some cases children were placed in homes with individuals convicted of kidnapping
22 and other serious crimes, with individuals who had substance abuse problems, and in the care
23 of caretakers who had previously failed foster care placements;^{3,5,6,7} and
24

25 Whereas, Investigations were conducted in only 15% of deaths with no subsequent action or
26 autopsy performed in all other deaths^{3,7}; and
27

28 Whereas, The report found that policies and procedures meant to monitor child welfare and
29 providers' performance and outcomes were not consistently followed³; and
30

31 Whereas, AMA policy H-515.960 exhorts "physicians [to] act as advocates for children, and as
32 such, have a responsibility legally and otherwise, to protect children when there is a suspicion of
33 abuse"; therefore be it
34

35 RESOLVED, That our American Medical Association support legislation requiring investigations
36 into the deaths of children in the foster care system that occur while the child is in the foster
37 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 atypical¹; 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 examination⁵; 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 scrutiny⁶; 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 restricted⁶; 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 performance⁹; 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 levels¹⁹; 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

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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 Medicine³ 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

1 Whereas, PAD is a decision made by a competent adult about how, when, where and with
2 whom to end life in the face of an irreversible terminal illness where continued living is not an
3 option, and therefore is not equivalent to or appropriately described as “suicide”, which can be
4 most accurately defined as a decision by a person to take his or her own life rather than to
5 continue living; and
6

7 Whereas, The American Association of Suicidology, in a treatise cited by CEJA¹², clearly states
8 that, “Suicide and physician aid in dying are conceptually, medically, and legally different
9 phenomena... the term ‘physician-assisted suicide’ in itself constitutes a critical reason why
10 these distinct death categories are so often conflated, and should be deleted from use.”; and
11

12 Whereas, Eight states and a federal district currently authorize PAD as an end-of-life option,
13 making PAD available to 21% of Americans, and sixteen additional states have introduced
14 legislation to enact it; and
15

16 Whereas, As determined by numerous polls and surveys, the overwhelming majority of the
17 public, consistently over 70% ⁴, supports PAD; and
18

19 Whereas, National surveys^{5,6,7,8,11} of physicians demonstrate increasing support for PAD (from
20 46% in 2010 to 57% in 2016) and decreasing opposition to PAD (from 41% in 2010 to 29% in
21 2016); and
22

23 Whereas, Surveys of physicians conducted by the Colorado Medical Society ⁶, the Maryland
24 State Medical Society ⁷, and the Massachusetts Medical Society⁸ found majorities in support of
25 PAD (56%, 54%, and 60% respectively); and
26

27 Whereas, There is no empirical evidence to substantiate the current description of PAD in
28 Opinion E-5.7 as a form of abandonment “of a patient once it is determined that cure is
29 impossible”, and in fact CEJA acknowledges that PAD is also considered to be “an expression
30 of care and compassion”; and
31

32 Whereas, Claims in the Code of Medical Ethics Opinion 5-7 that characterize PAD as “difficult or
33 impossible to control”, causing “more harm than good,” and posing “serious societal risks”, are
34 unsubstantiated and speculative based on data reviews ⁹ cited in CEJA Report-2 that find
35 conflicting interpretations but no definitive evidence to justify concerns for potential abuse; and
36

37 Whereas, It is widely acknowledged by patients, physicians and ethicists that suffering is not
38 limited to physical pain, but equally includes emotional suffering due to loss of autonomy, and a
39 loss of control over one’s destiny while an opportunity for such control clearly exists, as
40 evidenced by overwhelming attestations on the part of patients who have chosen the option of
41 PAD as having a sense of enormous relief and comfort, even by patients who in the end never
42 take the cocktail they’ve been prescribed; and
43

44 Whereas, “Engaged Neutrality”¹⁰ is a position that is neither “pro” nor “con”, but allows for the
45 expression of diverse views while ensuring safeguards and appropriate standards, educating
46 the public, care givers and physicians, and protecting physicians’ freedom to participate in or opt
47 out of PAD according to their own personal values; therefore be it

1 RESOLVED, That our American Medical Association Council on Judicial and Ethical Affairs be
2 strongly encouraged to remove from the Code of Medical Ethics Opinion E-5.7 “Physician-
3 Assisted Suicide” judgmental, stigmatizing language that is not evidence based, is at odds with
4 the conclusions of CEJA Report 2 in recognizing shared values of care, compassion, respect
5 and dignity, and creates an ethical conflict with the Code of Medical Ethics Opinion E-1.1.7
6 “Physician Exercise of Conscience”; specifically by:

- 7
- 8 (a) Deleting all references to “suicide”, including “Physician-assisted suicide” and replacing
 - 9 such language by referring to “Physician-assisted dying (PAD)”;
 - 10 (b) Deleting language that suggests that PAD is a form of doing harm and is therefore
 - 11 antithetical to the admonition to “do no harm”, such as “assisted suicide would ultimately
 - 12 cause more harm than good”;
 - 13 (c) Deleting language that characterizes PAD as a choice by a patient “that death is preferable
 - 14 to life” and replacing that language with a description of PAD as giving a terminally ill patient
 - 15 the option of being in control of the manner of his or her death, without assigning a value
 - 16 judgment to that option;
 - 17 (d) Deleting language that characterizes PAD as “fundamentally incompatible with the
 - 18 physician’s role as healer”, and instead recognizing that a physician who participates in PAD
 - 19 is doing so as an act of compassion and caring for patients who have no prospect of healing
 - 20 their fatal illness;
 - 21 (e) Delete language that suggests that PAD is not compatible with “responding to the needs of
 - 22 patients at the end of life” or that PAD is “abandonment” (Directive to Take Action); and be it
 - 23 further
 - 24

25 RESOLVED, In recognition of the fact that highly ethical physicians may have differing opinions
26 on Physician Assisted Dying (PAD), but also in recognition of our respect for patient autonomy
27 and the growing numbers of patients who wish to exercise choice over the manner of imminent
28 death, that our American Medical Association’s Council on Judicial and Ethical Affairs (CEJA)
29 be strongly encouraged to modify Code of Medical Ethics Opinion E-5.7 “Physicians-Assisted
30 Suicide” to follow the lead of a number of state and national medical societies by adopting the
31 ethical position of “Engaged Neutrality”, defined as neither in favor of nor or in opposition to
32 PAD, while providing reassurance that our AMA will be a resource to lawmakers, physicians and
33 the public to ensure compliance with standards of lawful medical practice, and to protect
34 physicians’ freedom to participate or not participate in PAD in accordance with their personal
35 beliefs and our AMA’s Opinion E-1.1.7 “Physician Exercise of Conscience”. (Directive to Take
36 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/y4odsufm>

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/y5dl4plg>

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

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/nchhstsp/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>.

1 Whereas, Food insecurity, for example, is associated with increased risk for diseases and
2 conditions like diabetes, hypertension, and depression in adults, and with increased risk for
3 impaired brain development, hospitalizations, iron-deficiency anemia, mental health, and
4 behavioral disorders in children;^{12,13,14,15,16} and

5
6 Whereas, Housing insecurity and homelessness are related to poorer physical health, including
7 higher rates of tuberculosis, hypertension, asthma, diabetes, and HIV/AIDS and higher rates of
8 medical hospitalizations; and

9
10 Whereas, Blue Cross Blue Shield of Massachusetts Foundation noted that there is strong
11 evidence that increased investment in selected social services as well as various models of
12 partnership between health care and social services can confer substantial health benefits and
13 reduce health care costs for targeted populations;¹⁷ and

14
15 Whereas, The social determinants of health play a key role in health outcomes and health
16 disparities, and that addressing the social determinants of health for patients and communities
17 is critical to the health of our patients, our communities, and a sustainable, effective health care
18 system; and

19
20 Whereas, Planning the most effective strategy(s) to provide health care coverage in the United
21 States is an evolving process, and will require careful evaluation, assessment, and modification;
22 and

23
24 Whereas, The core principles to guide the envisioned future reforms and goals of health care
25 have not been clearly stated; and

26
27 Whereas, Strategies to address future health care reforms and goals cannot be accomplished
28 without stating and acknowledging the principles that will serve as the compass by which
29 decisions will be made; and

30
31 Whereas, Physicians and medical societies should help define the principles upon which health
32 care reforms and goals are structured and speak with a single voice and acknowledge that
33 health is a basic right for every person in a just society, and not a privilege to be available and
34 affordable only for a majority; and

35
36 Whereas, Physician members of the AMA rightfully focus on the provision of health care and its
37 role in providing for the health of populations and a right to health care is only one aspect of a
38 larger right to health;¹⁸ and

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

1 Whereas, In addition to health care, a right to health encompasses a right to provision of social
2 measures including sufficient food and drinking water, adequate housing and working
3 conditions, satisfactory education;¹⁹ and
4

5 Whereas, Spending on social measures arguably has a greater aggregate impact on population
6 health than medical care;²⁰ and
7

8 Whereas, The United States currently gives limited attention to social programs and continues
9 to outspend its peers on medical care;²¹ and
10

11 Whereas, We as physicians share the professional responsibility to advocate for the health and
12 well-being of our patients; and
13

14 Whereas, We as the AMA have consistently affirmed our common belief that comprehensive
15 health care access should be available to all; and
16

17 Whereas, Principles to direct our AMA advocacy for patients should support a right to health, in
18 all its dimensions (including addressing social determinants of health and universal access to
19 timely, acceptable and affordable health care of appropriate quality care); and
20

21 Whereas, AMA policies on access to healthcare and its ongoing work and focus on social
22 determinants of health and preventive care would benefit from core principles that support future
23 advocacy and education; therefore be it
24

25 RESOLVED, That our American Medical Association acknowledge that enjoyment of the
26 highest attainable standard of health, in all its dimensions, including health care is a basic
27 human right (New HOD Policy); and be it further
28

29 RESOLVED, That the provision of health care services as well as optimizing the social
30 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)

1 Whereas, Involuntary civil commitment is defined by law as the commitment of a person who is
2 ill, incompetent, drug-addicted, or the like, without the consent of the person being committed;
3 and
4

5 Whereas, In response to the opioid crisis, the scope of these laws has rapidly expanded, as the
6 number of states with such laws went from 18 in 1991 to 38 jurisdictions in 2016¹; and
7

8 Whereas, Existing data on both the short- and long-term outcomes following involuntary civil
9 commitment for reasons related to substance-use disorder does not support its broad
10 utilization²; and
11

12 Whereas, Data suggests that coercive treatment puts patients at higher risk of fatal overdose³;
13 and
14

15 Whereas, The legal standards and procedures for involuntary civil commitment are very broad
16 and allow for the presiding judge to overrule the clinical determination of the commitment's
17 appropriateness; and
18

19 Whereas, Involuntary civil commitment of persons for reasons related to substance-use disorder
20 has already been implicated in human rights abuses and suicides⁴; and
21

22 Whereas, Overdose data has shown that people who were involuntarily committed were more
23 than twice as likely to experience a fatal overdose as those who completed voluntary treatment⁵;
24 and
25

26 Whereas, Our AMA urges the formulation of a comprehensive national policy on drug abuse
27 that should expand the availability and reduce the cost of treatment programs for substance use
28 disorders, including addiction (H-95.981, "Federal Drug Policy in the United States"); and
29

30 Whereas, Our AMA urges expanding the quantity and improving the quality of drug treatment
31 programs (H-95.973, "Increased Funding for Drug Treatment"); and
32

33 Whereas, Our AMA policy is that health promotion should be a collaborative, patient-centered
34 process that promotes trust and recognizes patients self-directed roles and responsibilities in
35 maintaining health (Code of Medical Ethics Opinion 8.11 Health Promotion and Preventive
36 Care)⁶; therefore be it

1 RESOLVED, That our American Medical Association oppose involuntary civil commitment
2 without judicial involvement of persons for reasons solely related to substance-use disorder
3 (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA work to advance policy and programmatic efforts to address gaps in
6 voluntary substance-use treatment services. (Directive to Take Action)

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

Received: 05/09/19

¹Involuntary 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>

²Nature 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/43/3/313.full.pdf>

³An Assessment of Opioid Related Deaths in Massachusetts (2013-2014) <https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf>

⁴Patients call Plymouth addiction center a mere jail - [The Boston Globe](#)

⁵<https://www.mass.gov/service-details/chapter-55-overdose-report>

⁶<https://www.ama-assn.org/delivering-care/ethics/health-promotion-and-preventive-care>

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)

1 Whereas, Medical oxygen is a prescription drug accessible only by physician prescription; and

2
3 Whereas, Clinical trials have demonstrated the effectiveness of supplemental oxygen to
4 address hypoxemia, improve exercise tolerance, and reduce mortality for patients with
5 respiratory or cardiac conditions; and

6
7 Whereas, Liquid oxygen is the optimal modality of delivering supplemental oxygen for patient
8 with high flow rates (>4 liters/minute), patients who do not tolerate oxygen conservation devices
9 or patients with high levels of ambulation; and

10
11 Whereas, Liquid oxygen systems were included into the CMS DME competitive bidding
12 program; and

13
14 Whereas, Medicare beneficiary utilization of liquid oxygen has dropped significantly since its
15 inclusion in the CMS DME competitive bidding program, dropping from 32,220 Medicare
16 beneficiaries on stationary liquid system in 2010 to 5948 in 2016 and dropping from 40938 liquid
17 portable Medicare beneficiaries in 2010 to 8141 in 2016; and

18
19 Whereas, Anecdotal reports from Medicare beneficiaries say DME companies who were
20 awarded competitive bidding contracts refused to supply liquid oxygen even though they were
21 contractually obligated to follow the physician prescription to provide liquid oxygen; and

22
23 Whereas, CMS in its proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and
24 Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2019
25 (CMS- 1691-P) recognized the problems in the liquid oxygen market but failed to propose or
26 finalize policy that would meaningfully address problems with Medicare beneficiary access to
27 liquid; therefore be it

28
29 RESOLVED, That our American Medical Association support policy to remove liquid oxygen
30 from the competitive bidding system and return payments for liquid oxygen to a Medicare fee
31 schedule basis (New HOD Policy); and be it further

32
33 RESOLVED, That our AMA convey its patient quality and access concerns for Medicare
34 beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for
35 Medicare and Medicaid Services, including the forthcoming proposed rule, Durable Medical
36 Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP)
37 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)

1 Whereas, Nearly 30 million Americans have hearing loss; and

2
3 Whereas, The average price for economy, mid-level, and premium technology receiver-in-the-
4 canal/ear hearing aids (RICs) is \$1388, \$2113, and \$2789 each; and

5
6 Whereas, Medicare does not allow any reimbursement for RIC's and the 65+ year old patient
7 who is in need of hearing amplification must pay for these devices out of pocket; and

8
9 Whereas, Untreated hearing loss has serious consequences and can result in depression,
10 social isolation, anxiety about participating in social settings, and even paranoia, according to a
11 study done by the National Council on the Aging; and

12
13 Whereas, The individual components of hearing aids cost anywhere from \$50 to \$150 per
14 device, and there is no transparency into the wide disparity between the components and the
15 ultimate price of a unit (one ear only) which can cost \$2500; and

16
17 Whereas, Ninety percent of the RICs sold in the United States are manufactured by only six
18 different companies; and

19
20 Whereas, If the cost of producing these devices could be brought down, and a patient had a
21 supplement from Medicare to allow the purchase, that more seniors would be able to afford
22 hearing amplification and enjoy the medical benefits that come with it; therefore be it

23
24 RESOLVED, That our American Medical Association urge Medicare to cover some or all of the
25 costs of a "reasonable" device for both ears if a patient has had an audiological exam that
26 identifies the need, and for Medicare to identify a vendor, or vendors, of hearing devices that
27 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)

1 Whereas, There are 11.3 million undocumented persons living in the United States and about
2 6,480 of these persons have end-stage renal disease (ESRD) for which undergoing routine
3 hemodialysis or transplant are life-sustaining treatments; and
4

5 Whereas, In 2016, there were an estimated 100,000 undocumented immigrants living in
6 Michigan that paid approximately \$87.6M in state and local taxes and \$15 billion in Social
7 Security payroll taxes annually, and have added \$300 billion to the \$2.7 trillion Social Security
8 Trust Fund; and
9

10 Whereas, Despite this substantial financial contribution to the American economy,
11 undocumented immigrants are considered “not qualified” by the United States Department of
12 Health and Human Services for 31 programs, resulting in denial of Medicaid, Medicare and
13 CHIP; and
14

15 Whereas, Undocumented individuals are unable to access federal subsidization for renal
16 transplant, therefore hemodialysis is the only treatment option for these patients; and
17

18 Whereas, Due to ineligibility for federal programs, most undocumented persons must pay out-
19 of-pocket for hemodialysis, which is cost prohibitive. This renders hospital emergency services
20 as the only option for care; and
21

22 Whereas, While emergency departments are mandated to provide coverage through the 1986
23 Emergency Medical Treatment and Active Labor Act (EMTALA) for emergent dialysis, they can
24 only provide one to two sessions per week (rather than the recommended three sessions per
25 week) and even then, high demand compromises the availability of dialysis chairs; and
26

27 Whereas, With a lack of consistent access to dialysis, many patients have experienced multiple
28 cardiac arrests and resuscitations and severe psychosocial distress leading to significant,
29 debilitating, and long-term health consequences that add further cost and burden to the health
30 care system; and
31

32 Whereas, Emergency-only hemodialysis patients experienced a five-year mortality rate greater
33 than 14-fold higher than patients undergoing scheduled maintenance dialysis, more ICU
34 admissions, and an almost 10-fold greater use of acute-care days; and
35

36 Whereas, Emergency-only dialysis annually costs approximately \$285,000 per patient versus
37 \$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)

1 Whereas, Telemedicine can encompass a range of services from health monitoring and patient
2 consultation to the transmission of medical records, but may be more broadly defined as any
3 electronic exchange of health information (per the American Telemedicine Association),
4 including the use of remote monitoring devices; and
5

6 Whereas, Telemedicine visits are increasing in frequency and have been shown to increase
7 access, reduce 30-day hospital readmission rates, and reduce total cost of care; and
8

9 Whereas, Telemedicine services are also helping to fill gaps in health care faced by patients
10 who struggle with mobility challenges, especially in rural communities; and
11

12 Whereas, Telemedicine services are also providing easy access for patients who appreciate
13 receiving care in a more convenient manner, often with a lower cost to the patient than an in-
14 office visit; and
15

16 Whereas, Primary care physicians are providing both synchronous (electronic exchange of
17 health information with a real-time video component) and asynchronous (electronic exchange of
18 health information without a real-time video component) telemedicine services for the benefit of
19 patients with a concurrent liability risk for these services; and
20

21 Whereas, Reimbursement for telemedicine services is currently allowed only for synchronous
22 telemedicine services (rural and non-rural settings) even though the expertise shared, and the
23 liability risk incurred have similar value and associated risk with a synchronous or an
24 asynchronous telemedicine visit; therefore be it
25

26 RESOLVED, That our American Medical Association work with third-party payers and the
27 Centers for Medicare and Medicaid Services at the national level to provide reimbursement for
28 both synchronous and asynchronous telemedicine services to encourage increased access and
29 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 Disorder⁵⁻⁷; 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 groups⁸⁻¹⁰; 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 therapy¹¹; 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 children¹²; 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 cap¹³; 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 model¹⁴; 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 dementia¹; 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 hospitalizations²; 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 life³; 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 two⁴; 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) Program⁸; and

Whereas, Only about half of the states have Medicaid programs that cover some aspects of hearing aids, exams, and related services, for adults⁹; 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 aids¹⁹; 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 aids¹²⁻²⁰; 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 solution⁸; 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, 2020²¹; 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)

1 Whereas, High-deductible health plans disincentivize patients from seeking appropriate health
2 care; and

3
4 Whereas, The 2009 Affordable Care Act (ACA) requires that preventive services recommended
5 by the US Preventive Services Task Force (USPSTF) be covered by insurers without a
6 deductible; and

7
8 Whereas, Outpatient visits for the care of common conditions, such as hypertension, diabetes,
9 coronary artery disease, hypothyroidism, etc., are not considered preventive, and therefore
10 require that the patient pay in full for these visits, until the deductible is met; and

11
12 Whereas, As a result, many patients decide not to get appropriate care for their health
13 conditions; and

14
15 Whereas, Several studies have found that improved access to a doctor's office to control
16 chronic disease and provide early treatment of medical problems will reduce total health care
17 costs through decreased use of emergency room and in-patient care¹; and

18
19 Whereas, In addition to their adverse effect on patients' access to care, high-deductible health
20 plans burden the economic viability of physician practices. While physicians are able to collect
21 copayments at the time of the visit, we are not able to charge for a deductible until a claim for
22 the visit has been submitted to the insurer, and the insurer has responded to the claim; and

23
24 Whereas, In the experience of many, physicians are usually not able to ascertain, at the time of
25 service, how much of the patient's deductible has been met; even if a patient will eventually be
26 found to be responsible for payment for the visit, the physician is unable to ask for payment at
27 the time of the visit; and

28
29 Whereas, This delay in submitting the claim to the patient inexorably leads to a decrease in the
30 collection rate for this portion of the fee. It is well known among private practice physicians that
31 there is a steady decrease in collection rate as time goes on after the visit; and

32
33 Whereas, In summary, high-deductible plans have a negative impact on patient health, may
34 increase total health care costs, and pose a threat to the economic viability of physician
35 practices; and

36
37 Whereas, One change that would provide significant relief to both patients and physicians would
38 be to exempt outpatient physician evaluation and management codes (99201–05 and
39 99211–15) from the deductible, for primary care and specialty practices; and

1 Whereas, There is precedent for this policy, in that the ACA requires that insurance plans
2 exempt preventive services recommended by the USPSTF from deductible payments; and
3

4 Whereas, Exempting these codes from payment of the deductible would improve patient access
5 to needed care, would likely reduce utilization of emergency room and in-patient services, and
6 would help to stabilize the economic viability of physician practices; therefore be it
7

8 RESOLVED, That our American Medical Association advocate for legislation or regulation
9 specifying that codes for outpatient evaluation and management services, including initial and
10 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

¹Nielsen 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)

1 Whereas, The AMA has policy supporting both prescription drug price transparency as well as
2 improved access to information about prescriptions drug prices and out-of-pocket costs for
3 patients; and
4

5 Whereas, The AMA does not have an updated policy addressing the fact that less expensive
6 purchasing options, such as alternative medications or generic formulations, may be available to
7 physicians at time of prescribing and patients at the time of purchase at a retail pharmacy; and
8

9 Whereas, The Administration has recently removed pharmacy 'gag clauses', banning retail
10 pharmacy restrictions on informing patients about differences in drug price with insurance
11 coverage, copayment, and out-of-pockets price of the medication, highlighting the importance of
12 price transparency on a federal level;^{1,2} and
13

14 Whereas, Most physicians and patients have limited access to the out-of-pocket cost of
15 medications due to the complexity of copays and formularies on different insurance plans,
16 prices and costs at different pharmacies; and
17

18 Whereas, Health and Human Services is in the early stages of determining how to utilize "Real-
19 Time Benefit check" to implement across all systems; and
20

21 Whereas, Barriers against prescription drug price transparency continue to limit the efficiency
22 and effectiveness with which health care providers can support informed clinical and financial
23 decision making for their patients;³ therefore be it

1 RESOLVED, That our American Medical Association amend policy H-110.991, "Price of
2 Medicine," by addition and deletion as follows:

3
4 Our AMA:

- 5 (1) work with relevant organizations to advocate for increased transparency through
6 access to meaningful and relevant information about medication price and out-of-pocket
7 costs for prescription medications sold at both retail and mail order/online pharmacies,
8 including but not limited to Medicare's drug-pricing dashboard; (1) advocates that
9 ~~pharmacies be required to list the full retail price of the prescription on the receipt along~~
10 ~~with the co-pay that is required in order to better inform our patients of the price of their~~
11 ~~medications;~~
12 (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health
13 plans to inform patients of the actual cash price as well as the formulary price of any
14 medication prior to the purchase of the medication;
15 (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that
16 prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's
17 cash price;
18 (4) will disseminate model state legislation to promote drug price and cost transparency
19 ~~and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies~~
20 ~~and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers~~
21 ~~about less-expensive options for purchasing their medication; and~~
22 (5) supports physician education regarding drug price and cost transparency,
23 manufacturers' pricing practices, and challenges patients may encounter at the
24 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)

1 Whereas, "Observation Status" for a hospitalization does not count to meet Medicare's "three
2 day inpatient rule" for "skilled nursing facility care" financial coverage; and
3

4 Whereas, "Observation Status" to a hospital means our patients are financially responsible for a
5 20 percent co-pay for hospital costs, the full cost of medications and diagnostic testing; and
6

7 Whereas, Our patients should present for emergency care assessment as soon as symptoms
8 and/or signs dictate, but the financial risks of "Observation Status" may dissuade patients from
9 seeking hospital based care through the emergency department; and
10

11 Whereas, Medicare Part A patients do not get a thorough explanation, including situational
12 examples, of Medicare coverage rules for "Observation Status" when pre-admitted or admitted
13 to a hospital; and
14

15 Whereas, There is no insurance available for Part A "Observation Status" financial risk;
16 therefore be it
17

18 RESOLVED, That our American Medical Association request, for the benefit of our patients'
19 financial, physical and mental health, that the Centers for Medicare and Medicaid Services
20 terminate the "48 hour observation period" and observation status in total. (Directive to Take
21 Action)

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

Received: 05/09/19

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)

1 Whereas, No scientific evidence exists that indicates mandatory echocardiogram or ECG
2 screening will save student athletes; and
3

4 Whereas, Operationalizing government oversight of mass screening is prohibitively expensive;
5 and
6

7 Whereas, The risk of "false positives" in mass screening environments is high and can lead to
8 unwarranted anxiety in normal athletes, unnecessary additional testing, and inappropriate
9 treatments and/or exclusion from sports; and
10

11 Whereas, The American Heart Association and the American College of Cardiology issued the
12 definitive Scientific Statement on mandatory EKG and echocardiogram screening of student
13 athletes on Sept. 15, 2014, and reaffirmed on Dec.1, 2015 in a Scientific Statement on Eligibility
14 and Disqualification Recommendations for Competitive Athletes, which stated, "Mandatory and
15 universal mass screening with 12-lead ECGs in large general populations of young healthy
16 people 12 to 25 years of age to identify genetic/congenital and other cardiovascular
17 abnormalities is NOT recommended for athletes and non-athletes alike (Class III, no evidence
18 of benefit; Level of Evidence C);"¹ and
19

20 Whereas, The lowest high school death rates ever reported come from Minnesota, which
21 mandates a comprehensive history and physical exam but not an echocardiogram or an ECG.
22 The Minnesota evidence demonstrates that ensuring every athlete provides an accurate history
23 and receives a quality exam is key to identifying those at greatest risk and avoiding
24 unnecessary worry and testing of healthy students; and
25

26 Whereas, A unique natural experiment that included both ECG and echocardiogram screening
27 identified diseases associated with sudden cardiac death in 0.38% of a large population during
28 a 20-year period, yet most of the small number of cardiac deaths were due to cardiomyopathies
29 not detected on screening;² therefore be it

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.

- 1 RESOLVED, That our American Medical Association and state and specialty medical societies
- 2 oppose legislation mandating echocardiograms or ECGs as a condition of participation in
- 3 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)

1 Whereas, In 2017, an estimated 16.7 million people aged 12 or older received substance use
2 disorder (SUD) treatment¹; and
3

4 Whereas, Substance use disorders (SUD) are medical conditions often co-occurring with other
5 medical conditions; and
6

7 Whereas, Integration of substance use disorder care with other medical care can help address
8 health disparities, reduce health care costs for both patients and family members, and improve
9 general health outcomes.²; and
10

11 Whereas, Well-supported scientific evidence shows that the traditional separation of substance
12 use disorder treatment from mainstream health care has created obstacles to successful care
13 coordination; and
14

15 Whereas, The continued separation of substance use disorder and general health care services
16 has been costly, often harmful, and for some individuals even fatal. A recent study showed that
17 the presence of a substance use disorder can double the odds that a person will develop
18 another chronic and costly medical illness, such as arthritis, chronic pain, heart disease, stroke,
19 hypertension, diabetes, or asthma.³; and
20

21 Whereas, The Federal Regulations mandating privacy protections for SUD treatment contained
22 in 42 CFR Part 2 was intended to protect SUD patient records maintained in connection with
23 certain programs or activities, but special SUD information protection may inadvertently
24 reinforce stigma against patients by reinforcing the belief that SUD is different from other health

¹Center 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.

²U.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.

³Scott, 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.

1 problems and must be kept more private. In turn, this stigma may inhibit the delivery of
2 comprehensive integrated care⁴; and
3

4 Whereas, The limited application of 42 CFR Part 2 to some substance use disorder treatment
5 facilities and the discrepancies between HIPAA and Part 2 are serious issues affecting the
6 integration and coordination of health care for patients with substance use disorders by
7 contributing to a separation of substance use disorder specialty care⁵; therefore be it
8

9 RESOLVED, That our American Medical Association support the alignment of federal privacy
10 law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act
11 (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring
12 protections are in place against the use of "Part 2" substance use disorder records in criminal
13 proceedings (New HOD Policy); and be it further
14

15 RESOLVED, That our AMA support the sharing of substance use disorder patient records as
16 required by the HIPAA Privacy Rule for uses and disclosures of protected health information for
17 treatment, payment and health care operations to improve patient safety and enhance the
18 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 130,600¹. According to the Georgia Physician Workforce, Georgia was ranked 39th in the nation for the number of practicing physicians per 100,000 people in 2016². According to a report by the AAMC, Georgia would need to add nearly 1,500 new residency slots to match the national rate²; 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 1997³; 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 country³; 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 country³; therefore be it

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.

1 RESOLVED, That our American Medical Association advocate for the Centers for Medicare and
 2 Medicaid Services (CMS) to adopt the concept of “Cap-Flexibility” and allow new and current
 3 Graduate Medical Education teaching institutions to extend their cap-building window for up to
 4 an additional five years beyond the current window (for a total of up to ten years), giving priority
 5 to primary care residencies (Directive to Take Action); and be it further
 6

7 RESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities
 8 prior to the arrival of any residents, removing the clause where “Medicare funding does not
 9 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)

1 Whereas, The opioid epidemic has led to increased emphasis on non-opioid treatment
2 approaches to pain; and
3

4 Whereas, In response to the opioid epidemic, several new laws were passed in the State of
5 Michigan in 2017 and became effective in 2018 which have further reduced the accessibility of
6 opioid-containing medications for the management of pain; and
7

8 Whereas, Research is increasingly showing that opioid therapy for chronic, non-malignant pain
9 is ineffective and may lead to hyperalgesia; and
10

11 Whereas, Patients need access to non-opioid forms of treatment to help treat their chronic, non-
12 malignant pain; and
13

14 Whereas, The sudden reduction in access to legally prescribed opioid-containing medications
15 has been implicated as possibly contributing to the increased use of illegal heroin and synthetic
16 opioid-containing medications; and
17

18 Whereas, Access to other proven modalities for effective pain treatment, such as physical
19 therapy, occupational therapy, and complementary and alternative medicine therapies which are
20 non-opioid treatment approaches, is of increasing importance in light of the sudden reduction in
21 access to opioid-containing medications and gabapentin; and
22

23 Whereas, Third party payers and the Centers for Medicare and Medicaid Services (CMS) have
24 not improved access to non-opioid treatment options for chronic pain through a reduction in co-
25 payment fees, a reduction in prior authorization requirements, a reduction in required prior
26 treatments, and/or an expanded list of acceptable indications for the various therapies; and
27

28 Whereas, This lack of improved access is leading to increased patient dissatisfaction,
29 decreased ability for physicians to provide adequate care for their patients with chronic pain or
30 any type of pain, possible increased use of illicit drugs by chronic pain patients as a way to
31 cope, and possible increased opioid-related overdose deaths as a result of the sudden
32 reduction in access to legally prescribed opioid-containing medications; therefore be it

- 1 RESOLVED, That our American Medical Association work with the Centers for Medicare and
- 2 Medicaid Services to improve access to non-opioid treatment modalities including, but not
- 3 limited to, physical therapy and occupational therapy as recommended by the patient's
- 4 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)

1 Whereas, The opioid epidemic has led to an increased focus on non-opioid-containing
2 medications to treat pain, especially chronic, non-malignant pain; and
3

4 Whereas, Research is increasingly showing that opioid therapy for chronic, non-malignant pain
5 is ineffective and may lead to hyperalgesia; and
6

7 Whereas, Topical lidocaine is effective for the treatment of pain; and
8

9 Whereas, Topical lidocaine has minimal side effects and is generally well tolerated; and
10

11 Whereas, Topical lidocaine is available over the counter in cream and transdermal patch forms;
12 and
13

14 Whereas, Lidocaine as a transdermal patch is an effective, topical pain treatment which may be
15 a reasonable alternative to opioid-containing medications; and
16

17 Whereas, Transdermal lidocaine has only one Food and Drug Administration-approved
18 indication for use as a prescribed medication (for the treatment of post-herpetic neuralgia) with
19 related limitations in insurance coverage; and
20

21 Whereas, Third-party payers will not provide prescription coverage for this medication for any off
22 label uses; and
23

24 Whereas, Other medications are occasionally covered by third party payers for off label uses if
25 other effective treatment options are unavailable or have limited availability; and
26

27 Whereas, Opioid and controlled substance laws and application of the Centers for Disease
28 Control and Prevention safe opioid prescribing guidelines are making access to opioid-
29 containing and non-opioid containing medications for the treatment of pain more limited;
30 therefore be it
31

32 RESOLVED, That our American Medical Association encourage the US Food and Drug
33 Administration to consider approving other indications in addition to post-herpetic neuralgia for
34 transdermal lidocaine patches (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA urge the Centers for Medicare and Medicaid Services and third-
- 2 party payers to provide insurance coverage of lidocaine transdermal patches for other
- 3 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)

1 Whereas, The United States Office of Disease Prevention and Health Promotion recognizes
2 economic stability as a social determinant of health¹; and
3

4 Whereas, The poverty rate in the United States has ranged from 11 to 15% over the past 50
5 years and, in 2016, over 95 million Americans lived below 200% of the poverty line²; and
6

7 Whereas, There is a breadth of research that shows that people with poverty-level income have
8 shorter life expectancies, increased rates of disease, decreased access to health care, and
9 fewer necessary resources including clean water, nutritional food, and safe neighborhoods³⁻⁷;
10 and
11

12 Whereas, Universal Basic Income provides every citizen over the age of 18, regardless of
13 income, with enough income to live just above the poverty line⁸⁻⁹; and
14

15 Whereas, Need-based assistance legislation does not address racial disparities, and differences
16 in policy across different states can worsen disparities¹⁰⁻¹³; and
17

18 Whereas, The inclusive nature of Universal Basic Income would simplify the welfare system by
19 consolidating current non-healthcare related assistance programs and implementing a
20 framework in which racial and other disparities are mitigated or eliminated entirely¹⁴; and
21

22 Whereas, It is estimated that currently demonstrated technology has the capability to automate
23 45% of tasks workers are paid to perform and Universal Basic Income could protect workers
24 from financial insecurity from future technological job elimination¹⁵⁻¹⁸; and
25

26 Whereas, Multiple studies have shown that cash transfer programs have led to health and
27 education benefits, including reduction in hospitalizations, increased organ function, decreased
28 incidence of psychiatric disorders and alcohol use, and increased educational attainment¹⁹⁻²⁵;
29 and
30

31 Whereas, Universal Basic Income could provide the benefits of a cash transfer program, and
32 may address one of the greatest flaws of a cash transfer program, which is that they have not
33 been shown to have a significant impact on employment²⁶⁻²⁸; and
34

35 Whereas, Government or private-sponsored Universal Basic Income pilot programs are ongoing
36 or scheduled to be conducted in Finland, Canada, Spain, Scotland, Kenya, and California in
37 order to determine the effects of Universal Basic Income including poverty reduction, better
38 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

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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)

1 Whereas, Blockchain is a distributed database that stores records of all transactions and digital
2 events carried out by its participants, called the public ledger, hosted across all participants
3 (nodes), rather than a central entity¹; and
4

5 Whereas, Once something has been added to the blockchain, it is permanently stored across all
6 nodes, and in this way, blockchain functions as a decentralized, immutable ledger capable of
7 storing data without the need for a central responsible entity, mitigating risk from central
8 failure²⁻⁴; and
9

10 Whereas, Blockchain may alleviate several pain points in the current state of information
11 sharing in health information technology, for example, allowing multiple stakeholders to agree
12 on the “true” state of data (immutable ledger), helping decrease administrative costs regarding
13 authorization and claims adjudication, better defining data ownership, and reducing
14 unauthorized data use through less burdensome computer code^{9,10}; and
15

16 Whereas, The 21st Century Cures Act defines health information technology (HIT)
17 interoperability as technology that “enables the secure exchange of electronic health
18 information with, and the use of electronic health information from, other health technology
19 without special effort on part of the user”⁶; and
20

21 Whereas, Interoperability positively impacts health systems in a variety of ways; including by
22 increasing operational efficiency, reducing clinical duplication/waste, and enhancing clinical care
23 by providing access to longitudinal data at the point of care⁷; and
24

25 Whereas, There has been a concerted effort, including through the AMA-driven Integrated
26 Health Model Initiative, to develop data structures that promote data sharing and standardize
27 output of data from proprietary EHRs to facilitate interoperability⁶⁻⁸; and
28

29 Whereas, In considering the security advantages and risks of blockchain technology compared
30 to contemporary approaches, each pillar of HIPAA (Administrative, Physical, Technical) must be
31 assessed under more precise definitions of security: Confidentiality and Unforgeability⁴; and
32

33 Whereas, Several case studies have shown that blockchain can mitigate risks related to mobile
34 data communication with EHRs through the use of smart contracts^{12,13}; and
35

36 Whereas, The advent of secure data sharing between mobile platforms via blockchain platforms
37 has potential to achieve incorporation of patient generated data routinely into daily clinical
38 decision making due to access at the point of care¹³; 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 interoperability 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 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 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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16. Lee JB, Park JY, Park J, Lim DJ, Kim SD, Chung HS. Clinical efficacy of radiofrequency cervical zygapophyseal neurotomy in

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)

1 Whereas, The mission of the AMA and affiliated state medical associations is to promote the art
2 and science of medicine, and the betterment of public health; and
3

4 Whereas, There is a current consolidation of the health insurance markets wherein 73% of
5 markets are highly concentrated and 46% have a single predominant carrier with greater than
6 50% of the market; and
7

8 Whereas, These predominant carriers control the market to the extent that independent
9 physician practices cannot survive if they do not participate with these carriers; and
10

11 Whereas, These carriers are unilaterally establishing practice algorithms and reporting
12 requirements which direct the physician work environment; and
13

14 Whereas, There is increasing national sentiment toward the development of a single payer
15 health care system; and
16

17 Whereas, Independent physicians are currently barred from collective bargaining activities by
18 federal antitrust law; therefore be it
19

20 RESOLVED, That our American Medical Association form a workgroup to outline the legal
21 challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further
22

23 RESOLVED, That this workgroup engage the state medical associations and other physician
24 groups as deemed appropriate (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA report by the 2020 Annual Meeting on the viability of a strategy for
27 the formation of a federal collective bargaining system for all physicians and, to the extent
28 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)

1 Whereas, The achievement of the Quadruple Aim of enhancing patient and clinician experience
2 of care, improving population health, and reducing costs requires evaluation and analysis of
3 data related to patient care; and
4

5 Whereas, The Centers for Medicare and Medicaid Services (CMS) is pursuing the achievement
6 of the Quadruple Aim through alternative payment programs, some of which involve
7 Accountable Care Organizations (ACO), networks of providers who take responsibility for the
8 quality and cost of care of a specified population; and
9

10 Whereas, Medicare claims data is provided to and collected by ACOs, that are combinations of
11 HIPAA Covered Entities working together in order to advance the coordination of care as a core
12 strategy to increase quality of care and decrease cost of care; and
13

14 Whereas, ACOs, as Business Associates of the Covered Entities in their networks, are bound
15 by HIPAA and Business Associate Agreements; and
16

17 Whereas, Opportunities to assess the impact of ACO interventions are lacking if the data cannot
18 be shared for research; and
19

20 Whereas, The Data Use Agreement (DUA) used by CMS's Centers for Medicare and Medicaid
21 Innovation (CMMI) for value based payment programs such as shared savings and Next
22 Generation, limits the use of data provided by CMS to ACOs and other users; and
23

24 Whereas, The restrictions in a DUA are generally intended to align with the objectives for the
25 data sharing, such as, for example, developing care models through ACOs that improve quality
26 and decrease costs; and
27

28 Whereas, The limitations in the DUA are greater than those posed by HIPAA that allows use of
29 similar data for research with full privacy protections and, therefore, the DUA poses an
30 additional barrier to research; and
31

32 Whereas, The DUA requires an ACO to obtain prior written authorization from CMS to
33 disseminate original or derived information from the files CMS shares with the ACO to anyone
34 who is not an ACO Participant, a Business Associate of an ACO Participant or a Covered Entity
35 in a treating relationship with the patient; and
36

37 Whereas, This limitation significantly impedes the ability of researchers to evaluate the efficacy
38 of ACO interventions and to investigate population health questions by impeding both: (1) the

1 ability to produce and use de-identified data sets as permitted by HIPAA and (2) the use of
 2 Medicare claims data held by ACOs for research as permitted by HIPAA; and

3
 4 Whereas, In the current situation, ACOs may use CMS data for internal quality improvement
 5 initiatives, but may not share their results in the descriptive, observational quality improvement
 6 literature; and

7
 8 Whereas, ACOs, governmental payers, academics, health care providers, academics and
 9 patients would benefit from efficacy and other research; and

10
 11 Whereas, The improvement of quality, cost, and patient satisfaction are all advanced by quality
 12 improvement literature; therefore be it

13
 14 RESOLVED, That our American Medical Association, in an effort to advance the feasibility of
 15 population health research to fulfill the promise of value based care, request that the Centers for
 16 Medicare and Medicaid Services (CMS) and CMS's Centers for Medicare and Medicaid
 17 Innovation (CMMI) eliminate the prohibitions on sharing data outside of the accountable care
 18 organization contained in the CMS Data Use Agreement and allow sharing of that data: (1) in
 19 the form of de-identified data sets as permitted by HIPAA; and (2) for purposes of research as
 20 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 Congress 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

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)

1 Whereas, The Association of American Medical Colleges (AAMC) reports that enrollment rates
2 among underrepresented minorities remain significantly low despite a rise in total medical
3 student matriculation rates that exceed 21,000 medical students¹; and
4

5 Whereas, All premed pipeline programs struggle to track former participants and whether they
6 enrolled in medical school; and
7

8 Whereas, Without accurate data on the effectiveness and influence of premed pipeline
9 programs on medical school enrollment; and
10

11 Whereas, 133 out of 141 American medical schools use the AAMC electronic medical school
12 application (AMCAS), offering an unparalleled opportunity to gather data on pipeline program
13 participation in medical school applicants; therefore be it
14

15 RESOLVED, That our American Medical Association collaborate with the Association of
16 American Medical Colleges (AAMC) and other stakeholders to coalesce the data to create a
17 question for the AAMC electronic medical school application to allow applicants to identify
18 previous pipeline program participation to determine the effectiveness of pipeline programs
19 those who are underrepresented in medicine in their decisions to pursue careers in medicine
20 (Directive to Take Action); and be it further
21

22 RESOLVED, That our AMA develop a plan to analyze the data once this question is
23 implemented with input from key stakeholders, including AAMC, the Accreditation Council for
24 Graduate Medical Education, and interested medical societies and premed pipeline programs.
25 (Directive to Take Action)

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

Received: 05/09/19

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)

1 Whereas, Opioids are attributed to over 47,000 overdose deaths in 2017 according to the
2 Centers for Disease Control and Prevention; and
3

4 Whereas, Approximately 130 Americans die every day from an opioid overdose, culminating in
5 nearly 48,000 drug overdose deaths involving an opioid in 2017; and
6

7 Whereas, Being the primary source of legally prescribed controlled substances, it is the
8 responsibility of physicians to learn safe, optimal prescribing practices for opioids; and
9

10 Whereas, Health professionals, attendings and residents included, often lack the confidence
11 and preparation to approach complex patients who are taking opioids for chronic pain; and
12

13 Whereas, It has been shown that some medical school curricula may not adequately spend
14 substantial time covering addiction medicine, or lack emphasis on the complexity of opioid
15 substance use disorder; and
16

17 Whereas, There is no current standardized curriculum regarding addiction and drug overdose
18 patient care for Medical Schools; and
19

20 Whereas, Prior training initiatives in Medical Schools regarding substance abuse disorders have
21 correlated with significant improvements in students' attitudes, beliefs in role responsibility, and
22 confidence in skills during preclinical years; and
23

24 Whereas, The Association of American Medical Colleges created a statement that 74 medical
25 schools signed in order to demonstrate their willingness toward better incorporating opioid-
26 related topics in their training of medical students; and
27

28 Whereas, There have been successful implementation of interprofessional education workshops
29 in medical schools that simulate the complex issues of substance use disorder while highlighting
30 the importance of collaborative teamwork; and
31

32 Whereas, An eight-hour medication-assisted treatment (MAT) waiver training for medical
33 students is offered by the Providers Clinical Support System, a program funded by the
34 Substance Abuse and Mental Health Services Administration; and
35

36 Whereas, Medical schools can partner with the American Society of Addiction Medicine to
37 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)

1 Whereas, A Physician Health Program is defined as a “confidential resource for physicians,
2 other licensed health care professionals, or those in training suffering from addictive,
3 psychiatric, medical, behavioral or other potentially impairing conditions;” and
4

5 Whereas, The Physician Health Program (PHP) model represents a system in which physicians
6 with potentially impairing conditions who come forward or are referred are given the opportunity
7 for evaluation, rehabilitation, treatment and monitoring without disciplinary action in an
8 anonymous, confidential and respectful manner; and
9

10 Whereas, Ideally, the PHP model is committed to the early identification, evaluation, treatment,
11 monitoring, and earned advocacy, when appropriate, of licensees with potentially impairing
12 qualifying illness(es) prior to the progression to impairment in the workplace; and
13

14 Whereas, The PHP model enables effective clinical care for mental, physical and substance
15 abuse disorders, easy access to a variety of clinical interventions and support for those seeking
16 help, including hospitals, families, communities, licensure boards and other components of
17 society and organized medicine; and
18

19 Whereas, PHPs, organized medicine, and the respective regulatory entities should work together
20 to advance the principles of collaboration, communication, accountability and transparency to
21 achieve a shared vision of ensuring the health their mutual constituencies while simultaneously
22 ensuring the safety and welfare of patients; and
23

24 Whereas, Considering the high costs of recruitment and training, the PHP model can save
25 organizations significant resources for each physician or physician assistant who is retained in,
26 or returned to, practice as the operation of the program, and rehabilitation of health care
27 professionals is more cost effective than the training of new health care professionals; and
28

29 Whereas, PHPs operate in 47 states and the District of Columbia; and
30

31 Whereas, Physicians can be referred to a PHP by their employer, a colleague, a family member,
32 or even themselves; and

1 Whereas, PHPs were created with the intention to provide a confidential pathway to rehabilitate
2 and monitor physicians with mental illness, substance use disorders, and other potentially
3 impairing conditions so that they may return safely to the practice of medicine; and
4

5 Whereas, In order to earn the confidence, respect, and trust of those they serve, PHPs must be
6 committed to having open lines of communication between all parties involved in carrying out its
7 mission, as well as honest, direct and professional interactions aimed toward common interests;
8 and
9

10 Whereas, PHPs must report to the state licensing board any physician suffering from serious
11 psychiatric illness, drug or alcohol use disorders, or any condition it deems to be currently
12 impairing and may place the public at risk if said physician refuses their recommendation for
13 treatment and subsequent disease management; and
14

15 Whereas, The Federation of State Medical Boards called for PHPs to develop performance
16 reviews of their programs that demonstrate an ongoing track record of ensuring safety to the
17 public and to reveal deficiencies if they occur, and thus ensure soundness and fairness of
18 practice; and
19

20 Whereas, The Federation of State Physician Health Programs (FSPHP) has the stated mission
21 of supporting physician health programs in improving the health of medical professionals,
22 thereby contributing to quality patient care; and
23

24 Whereas, The FSPHP strengthens PHPs by promoting best practices and providing guidelines,
25 advocacy, and other resources that enhance their effectiveness. The FSPHP encourages
26 partnerships between physician health programs, regulatory boards, and other appropriate
27 components of organized medicine; and
28

29 Whereas, The FSPHP fosters collaboration and engagement with other national and
30 international medical organizations; and
31

32 Whereas, The FSPHP opposes discrimination against physicians and the medical community
33 solely based on the presence of a particular diagnosis or other discriminatory factors and
34 supports the use of PHP services in lieu of disciplinary action whenever possible; and
35

36 Whereas, The FSPHP supports education and research designed to establish best practices for
37 the prevention, treatment, and monitoring of physicians experiencing substance use disorders,
38 mental illness, physical illness, and other potentially impairing conditions; and
39

40 Whereas, The FSPHP's guidelines and philosophy are consistent with the American Medical
41 Association (AMA) Physician Health Program Model ACT
42 https://www.fsphp.org/assets/docs/ama_physicians_health_programs_act_-_2016.pdf; and
43

44 Whereas, The FSPHP is currently developing the Performance *Enhancement and Effectiveness*
45 *Review* (PEER™) program to improve accountability, consistency, and excellence among state
46 PHPs; and
47

48 Whereas, The AMA, the American Psychiatric Association, the Accreditation Council of
49 Graduate Medical Education, the American Board of Medical Specialties, the American
50 Osteopathic Association, the American College of Physicians and the FSMB have all sponsored
51 the FSPHP PEER™ process via philosophical, financial, and stated support that reflect a

1 commitment to further the development of these important programs while at the same time set
 2 the stage for appropriate funding for this venture; therefore be it
 3

4 RESOLVED, That our American Medical Association amend policy D-405.990, "Educating
 5 Physicians About Physician Health Programs," by addition to read as follows:
 6

7 Educating Physicians About Physician Health Programs and Advocating for
 8 Standards D-405.990

9 1) Our AMA will work closely with the Federation of State Physician Health Programs
 10 (FSPHP) to educate our members as to the availability and services of state physician
 11 health programs to continue to create opportunities to help ensure physicians and
 12 medical students are fully knowledgeable about the purpose of physician health
 13 programs and the relationship that exists between the physician health program and
 14 the licensing authority in their state or territory; 2) Our AMA will continue to collaborate
 15 with relevant organizations on activities that address physician health and wellness; 3)
 16 Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines
 17 addressing the design and implementation of physician health programs; ~~and~~ 4) Our
 18 AMA will work with FSPHP to develop messaging for all Federation members to
 19 consider regarding elimination of stigmatization of mental illness and illness in general
 20 in physicians and physicians in training; and 5) Our AMA will continue to work with
 21 and support FSPHP efforts already underway to design and implement the physician
 22 health program review process, Performance Enhancement and Effectiveness Review
 23 (PEER™), to improve accountability, consistency and excellence among its state
 24 member PHPs. The AMA will partner with the FSPHP to help advocate for additional
 25 national sponsors for this project; 6) Our AMA will continue to work with the FSPHP
 26 and other appropriate stakeholders on issues of affordability, cost effectiveness, and
 27 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 2010¹; 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 discrepancy²; 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 so⁵⁻⁸; 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

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)

1 Whereas, The current recommended process for immunization of asylum seekers to the United
2 States involves immunization assessment and as indicated vaccine administration in overseas
3 camps prior to embarkment to the US; and
4

5 Whereas, Refugees are currently not legally required to get vaccinations before US
6 resettlement; and
7

8 Whereas, There currently exists a partnership between the CDC, the Bureau of Population,
9 Migration, and Refugees, and the Department of State; and
10

11 Whereas, The vaccinations are provided at reduced price through the Unicef Program; and
12

13 Whereas, The increase in asylum seekers who are entering the US by foot without prior
14 positioning in an overseas camp situation makes vaccination prior to arrival impossible; and
15

16 Whereas, There remains a resurgence of vaccine-preventable diseases being disseminated
17 during the asylum seeker's journey and processing, in addition to that among current US
18 residents; and
19

20 Whereas, Current US residents are eligible to receive Vaccine for Children (VFC) immunizations
21 at considerably reduced cost; and
22

23 Whereas, Immunizations remain one of the greatest health promotion accomplishments of our
24 time; therefore be it
25

26 RESOLVED, That our American Medical Association call for asylum seekers to receive all
27 medically-appropriate vaccinations upon presentation for asylum regardless of country of origin.
28 (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 US¹; and

Whereas, In 2017, approximately 1.4 million people made at least one suicide attempt and of those successful, 50.57% were achieved by firearms²; 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 population¹; 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

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, Orlovskaya S, Mofaddi 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.

1 RESOLVED, That our American Medical Association reaffirm current AMA policy,
 2 H-145.999, "Gun Regulation," stating it supports stricter enforcement of current federal and
 3 state gun legislation (Reaffirm HOD Policy); and be it further
 4

5 RESOLVED, That our AMA advocate for physician-led committees in each state to give further
 6 recommendations to the state regarding driving and/or gun use by individuals who are
 7 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)

1 Whereas, A higher percentage of U.S. drivers text or use hand-held cell phones while driving
2 compared to drivers in European countries; and
3

4 Whereas, The CDC states that in 2016, 3,450 people were killed in crashes involving a
5 distracted driver; and
6

7 Whereas, The CDC also found that in 2015, 391,000 people were injured in motor vehicle
8 crashes involving a distracted driver; and
9

10 Whereas, One-fourth of all traffic accidents are associated with cell phone use; and
11

12 Whereas, Sixteen states and the District of Columbia have laws in place banning hand-held cell
13 phone use and texting; therefore be it
14

15 RESOLVED, That our American Medical Association make it a priority to create a national
16 education and advocacy campaign on distracted driving in collaboration with the Centers for
17 Disease Control and other interested stakeholders (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA explore developing an advertising campaign on distracted driving
20 with report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take
21 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)

1 Whereas, In 1976, the Supreme Court of the United States¹ and other courts ruled that all
2 persons incarcerated in the United States are entitled to “reasonably adequate health care,
3 meaning “services at a level reasonably commensurate with modern medical science and a
4 quality acceptable within prudent professional standards”; and
5

6 Whereas, The American Medical Association developed a set of standards for health care
7 provided to prisoners of jails, prisons, and juvenile detention facilities during the 1970s which
8 were later adopted by the National Commission on Correctional Health Care; and
9

10 Whereas, There are organizations that have created standards of correctional health care
11 services and support and regularly survey facilities; and
12

13 Whereas, Correctional facilities voluntarily seek NCCHC accreditation which involves a review
14 of the facility’s condition by external clinical professionals to determine whether they meet
15 NCCHC accreditation; and
16

17 Whereas, The American Correctional Association (ACA) provides similar guidelines and an
18 opportunity for voluntary accreditation and compliance monitoring; and
19

20 Whereas, Being an accredited facility has distinct advantages including: 1) ensuring proper
21 health care is provided, 2) demonstrating to the public that the facility has taken steps to care
22 for those incarcerated, 3) promoting the health of a vulnerable segment of society and 4)
23 contributing to the welfare of the public by lessening its financial health care burden; and
24

25 Whereas, At the present time, only approximately 15% of the nearly 7,000 penal facilities in the
26 United States are accredited; and
27

28 Whereas, The Federal government has enacted the First Step Act (Formerly Incarcerated
29 Reenter Society Transformed Safely Transitioning Every Person Act) in its recognition of
30 concerns of incarceration; therefore be it

References:

¹ Estelle v. Gamble, 429 U.S. 97 (1976).

1 RESOLVED, That our American Medical Association work with an accrediting organization,
 2 such as National Commission on Correctional Health Care (NCCHC), American Correctional
 3 Association (ACA) and others with accreditation expertise, in developing a strategy to accredit
 4 all correctional, detention and juvenile facilities (Directive to Take Action); and be it further
 5

6 RESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be
 7 accredited by a national accrediting organization, such as the NCCHC or ACA, no later than
 8 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-

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)

1 Whereas, Individuals who are visually impaired or developmentally disabled rely on public and
2 private means for transportation; and
3

4 Whereas, The functionality of autonomous or “self-driving” vehicles span a range from almost
5 complete driver engagement to no driver engagement whatsoever; and
6

7 Whereas, Implementation of proven autonomous vehicles may result in reduced automobile
8 accidents and occupant injury or death, with the consequence of lower health care costs,
9 improved public safety, and lower automobile insurance cost; and
10

11 Whereas, Most autonomous vehicles currently under development are generally at a level
12 where driver monitoring and engagement is essential for safe driving; and
13

14 Whereas, Individuals who are visually impaired or developmentally disabled may not meet the
15 requirements necessary for monitoring an autonomous vehicle at the current level of
16 automation, and therefore would not qualify to operate such vehicles; therefore be it
17

18 RESOLVED, That our American Medical Association work with the National Transportation
19 Safety Board to support physician input on research into the capability of autonomous or “self-
20 driving” vehicles to enable individuals who are visually impaired or developmentally disabled to
21 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)

1 Whereas, Electronic nicotine delivery systems (ENDS) produce an aerosol by heating a liquid
2 that usually contains nicotine, flavorings and other harmful chemicals; and
3

4 Whereas, Nicotine is an addictive drug that can harm the developing adolescent brain; and
5

6 Whereas, ENDS aerosol can contain harmful and potentially harmful substances, including
7 nicotine, ultrafine particles, volatile organic compounds, cancer-causing chemicals, and heavy
8 metals such as nickel, tin, and lead; and
9

10 Whereas, The health impacts of inhaling such chemicals is still being investigated but
11 preliminary reports indicate that some ingredients could be harmful to the lungs in the long-term;
12 and
13

14 Whereas, The United States Surgeon General recently declared youth e-cigarette use an
15 epidemic; and
16

17 Whereas, According to the Centers for Disease Control and Prevention, nearly 1 of every 20
18 middle school students (4.9%) reported in 2018 that they used electronic cigarettes in the past
19 30 days and nearly 1 of every 5 high school students (20.8%) reported the same; and
20

21 Whereas, Although the impact of such utilization remains to be fully appreciated, it is clear the
22 health impacts and the potential of creating significant health risks parallels the early years of
23 tobacco; and
24

25 Whereas, Big tobacco markets to youth via sweet flavoring, product design and ads with
26 deliberate intent on addicting future adult users; therefore be it

1 RESOLVED, That our American Medical Association amend existing policy H-495.986, "Sales
2 and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and
3 E-cigarettes," by addition to read as follows:
4

5 Our AMA:

6 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic
7 and will actively work with the Food and Drug Administration and other relevant
8 stakeholders to counteract the marketing and use of addictive e-cigarette and vaping
9 devices, including but not limited to bans and strict restrictions on marketing to minors
10 under the age of 21 and requirements to include warning labels on all electronic
11 nicotine delivery systems (ENDS);

12 (2) encourages the passage of laws, ordinances and regulations that would set the
13 minimum age for purchasing tobacco products, including electronic nicotine delivery
14 systems (ENDS) and e-cigarettes, at 21 years and require warning labels on all ENDS,
15 and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;

16 (3) supports the development of model legislation regarding enforcement of laws
17 restricting children's access to tobacco, including but not limited to attention to the
18 following issues: (a) provision for licensure to sell tobacco and for the revocation
19 thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license
20 revocation) to deter violation of laws restricting children's access to and possession of
21 tobacco; (c) requirements for merchants to post notices warning minors against
22 attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d)
23 measures to facilitate enforcement; (e) banning out-of-package cigarette sales
24 ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking
25 age; and (g) requirements for warning labels on all ENDS;

26 (4) requests that states adequately fund the enforcement of the laws related to tobacco
27 sales to minors;

28 (5) opposes the use of vending machines to distribute tobacco products and supports
29 ordinances and legislation to ban the use of vending machines for distribution of
30 tobacco products;

31 (6) seeks a ban on the production, distribution, and sale of candy products that depict
32 or resemble tobacco products;

33 (7) opposes the distribution of free tobacco products by any means and supports the
34 enactment of legislation prohibiting the disbursement of samples of tobacco and
35 tobacco products by mail;

36 (8) (a) publicly commends (and so urges local medical societies) pharmacies and
37 pharmacy owners who have chosen not to sell tobacco products, and asks its
38 members to encourage patients to seek out and patronize pharmacies that do not sell
39 tobacco products; (b) encourages other pharmacists and pharmacy owners individually
40 and through their professional associations to remove such products from their stores;
41 (c) urges the American Pharmacists Association, the National Association of Retail
42 Druggists, and other pharmaceutical associations to adopt a position calling for their
43 members to remove tobacco products from their stores; and (d) encourages state
44 medical associations to develop lists of pharmacies that have voluntarily banned the
45 sale of tobacco for distribution to their members; and

46 (9) opposes the sale of tobacco at any facility where health services are provided; and

47 (10) supports that the sale of tobacco products be restricted to tobacco specialty
48 stores. (Modify Current HOD Policy)

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

Received: 05/09/19

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2. U.S. Department of Health and Human Services. (2018). Surgeon General releases advisory on E-cigarettes epidemic among youth. Retrieved from <https://www.hhs.gov/about/news/2018/12/18/surgeon-general-releases-advisory-e-cigarette-epidemic-among-youth.html> 2015-2016 and 2017-2018
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 2016¹⁻²; 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% Hispanic³⁻⁴; 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 lives⁵; 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 White⁵; 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 health⁶⁻⁹; 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 distress¹⁰; 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 abuse¹¹⁻¹²; 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 youth¹³; 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 incarceration¹⁴; and

Whereas, Established intervention programs aimed at improving the interactions between children and their incarcerated parents include interventions such as having parents record

1 themselves reading their child a book and providing incarcerated parents, their children, and the
2 child's interim caregiver with in-person visits, individual counseling and family skill sessions; and
3

4 Whereas, Established intervention programs have shown to increase student performance and
5 interest in school, improve familial functioning, and improve parental mental health¹⁵⁻¹⁶; and
6

7 Whereas, Even increased telephone and written letter contact between children and their
8 incarcerated parents resulted in fewer child behavioral problems and improved mental
9 health¹⁷⁻¹⁸; and
10

11 Whereas, Established intervention programs identify arranging visits, the privacy of the parent-
12 child interactions, the need for more interaction with case workers, and the lack of sufficient
13 training for program providers as barriers to providing better services¹⁹; and
14

15 Whereas, The AMA policy H-430.990 has previously supported further research on and
16 implementation of programs to promote maternal/child bonding among incarcerated mothers²⁰;
17 and
18

19 Whereas, The 115th Congress introduced a House of Representatives resolution (H.Res.623)
20 that recognizes the importance of providing services to children of incarcerated parents²¹; and
21

22 Whereas, The House of Representatives passed H.Res.5682 passed which requires that
23 federal prisoners to be placed within 500 miles of their families in an attempt to improve
24 parental-child contact with the aim of reducing recidivism²²; therefore be it
25

26 RESOLVED, That our American Medical Association support legislation and initiatives that
27 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)

1 Whereas, Compassionate release, sometimes called “early medical parole” or “early medical
2 release” describes a range of policies that allow incarcerated individuals who have a serious or
3 debilitating medical condition and/or advanced age to secure early release from an existing
4 sentence^{1,2}; and
5

6 Whereas, The aging incarcerated population is increasing exponentially, with the number of
7 state prisoners over age 55 quadrupling from 6300 to 25,700 between 1993 and 2013³; and
8

9 Whereas, Cancer and heart disease are the two leading causes of death in prisons and jails,
10 both of which are associated with advanced age⁵; and
11

12 Whereas, Aging incarcerated individuals require medically-appropriate accommodations,
13 including ramps, lower bunks, handicapped-accessible cells, and assistance with feeding, which
14 many facilities are unable to provide due to old infrastructure, overcrowding, and lack of
15 appropriate training for staff^{4,6,7}; and
16

17 Whereas, Few facilities have special units for incarcerated individuals with cognitive
18 impairments, and these individuals must rely on fellow incarcerated people for support⁴; and
19

20 Whereas, Incarcerated people have a constitutional right to adequate medical care;⁸ and
21

22 Whereas, Existing AMA policy affirms that it believes in “preserving dignity and self-respect of
23 all individuals at all ages” (H-25.997); and
24

25 Whereas, Although 49 states and the District of Columbia have laws that permit compassionate
26 release, few incarcerated individuals can receive early release because these state laws are
27 inconsistent, confusing, do not delineate a clear process, or contain overly strict eligibility
28 criteria²; and
29

30 Whereas, For example, Arizona requires compassionate release applicants to be facing
31 “imminent death,” but has three different definitions of “imminent death” among Department of
32 Corrections and Board of Executive Clemency documents;² and
33

34 Whereas, The eligibility criteria in Maryland’s medical parole statute are different from those
35 listed in the Code of Maryland Regulations²; and
36

37 Whereas, Michigan does not have any guidelines for the implementation of its compassionate
38 release policy whatsoever²; 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 Paroles²; 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 months²; 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 outcomes²; 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 guidelines¹²; 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 prognosis¹²; 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 waiting¹³; 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 diet¹; and

Whereas, Nutrient density refers to the nutrient to energy content ratio of foods and/or diets²; 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 gain⁹⁻¹³; 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 patient²; 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 transmission⁴; 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 suppression⁵; 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 ART⁶⁻⁸; 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 literature⁹; 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 suppressed¹⁰; 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 behaviors¹¹; 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 liability¹¹⁻¹⁶; 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-disclosure³; 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)

1 Whereas, When communities formed governments in the US, most created a public health
2 authority and system with legal authority to monitor environmental hazards and stressors,
3 surveil the health status of the population within its geographic confines and conduct activities to
4 reduce hazards, protect and improve health for their respective population; and
5

6 Whereas, Advances to improve health through enhanced monitoring, surveillance and
7 intervention have greatly expanded, most community public health authorities have not been
8 able to effectively and efficiently incorporate these advances to address changing morbidity
9 resulting from new societal conditions; and
10

11 Whereas, Factors contributing to this failure of optimal rural public health include but are not
12 limited to:
13

- 14 – Increased prevalence of chronic disease that accompanies an aging population
- 15 – Increased prevalence of mental health and addiction disorders leading to increased
16 morbidity and mortality
- 17 – Generational changes in family care dynamics
- 18 – Limited patient health literacy and understanding of complex disease
- 19 – Fragmentation and duplication of services as a result of absent systems of
20 coordination within and between physicians, providers and community-based public
21 health personnel
- 22 – Inadequate funding for community-based approaches to addressing and positively
23 impacting social determinants
- 24 – Decline of local specialty care for critical specialties that are directly related to the
25 health of a community (e.g., obstetrics)
- 26 – Inability to attract qualified public health leadership professionals for rural communities;
27 and
28

29 Whereas, Despite these obstacles, the greatest challenge to restoring high quality community
30 public health systems is the ability of local political authorities, health care practitioners and
31 institutions to study and identify these changes and obstacles; and
32

33 Whereas, There is a current lack of accountability between local, state and federal authorities to
34 take ownership of rural public health needs; and
35

36 Whereas, The nature, intensity and scope of needs and resources vary among community
37 systems while the essential functions to address them do not; therefore be it

1 RESOLVED, That our American Medical Association work with other entities and organizations
2 interested in public health to:

3
4 - Identify and disseminate concrete examples of administrative leadership and
5 funding structures that support and optimize local, community-based rural public
6 health

7
8 - Develop an actionable advocacy plan to positively impact local, community-based
9 rural public health including but not limited to the development of rural public health
10 networks, training of current and future rural physicians in core public health
11 techniques and novel funding mechanisms to support public health initiatives that
12 are led and managed by local public health authorities

13
14 - 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 aides. 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 them 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)

-
- 1 Whereas, The use of marijuana has increased due to the medical marijuana program and will
2 increase further when marijuana is legalized for recreational use; and
3
4 Whereas, Physicians have to make marijuana related treatment decisions based on data from
5 anecdotal observations and poorly conducted studies; therefore be it
6
7 RESOLVED, That our American Medical Association petition the US Food and Drug
8 Administration / US Drug Enforcement Administration to change the schedule classification of
9 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

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 manufactured 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

- 1 RESOLVED, That our AMA work with medical specialty societies to preserve a physician's
- 2 ability to prepare medications in physicians' offices and be able to do so without being subject to
- 3 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)

1 Whereas, It was revealed that certain lots of valsartan, losartan and irbesartan tablets contained
2 trace amounts of N-Nitroso-dimethylamine (NDMA) and N-Nitrosodiethylamine (NDEA), which are
3 classified as cancer causing substances; and
4

5 Whereas, The recalls resulting from identification of these pharmaceutical issues result in
6 generalized recalls to patients as the lots/batches are not identifiable at the patient level; and
7

8 Whereas, The FDA has recently announced increasing the allowable nitrosamine contaminant
9 level 100X for 6 months due to drug supply demands and the inability ensure an
10 uncontaminated supply; and
11

12 Whereas, The FDA has recently announced the finding that specific lots of losartan/valsartan
13 are contaminant free, emphasizing the importance and resolution of batch-level testing; and
14

15 Whereas, There are roughly 3 drug recalls per day, and roughly 100 recalls per year are
16 associated with the risk of death; and
17

18 Whereas, A 2015 AMA study outlining factors leading to non-adherence identified mistrust and
19 fear as significant factors leading to medication non-adherence, and a 2018 survey through
20 Google consumer surveys identified mistrust in generics as being a major factor leading to
21 medication non-adherence; and
22

23 Whereas, A 2015 FDA white paper reported the FDA has no formal means for quality
24 surveillance, except through inspections; and inspection findings have not been a reliable
25 predictor of the state of quality; and
26

27 Whereas, A 2010 Harvard Medical School Study showed lot-to-lot variability in anti-epileptic
28 medications causes a 2.3X increased incidence of seizures; and
29

30 Whereas, Medication dissolution analysis has shown significant variability in dissolution from
31 test state to physiological conditions, resulting in potentially clinically relevant differences in
32 patient absorption; and
33

34 Whereas, The industry recognizes the importance of tracing lots which was enacted into law via
35 the Drug Supply Chain Security Act of 2013, but the lots are not required to be connected to
36 patients; and

1 Whereas, Private industry has started performing batch validation on pharmaceuticals which are
2 documented, and traceable; and these pharmaceuticals are accessible to patients and other
3 pharmaceutical distributors; therefore be it
4

5 RESOLVED, That our American Medical Association do a study and report back by the
6 2019 Interim Meeting regarding the pharmaceutical variability, both in active pharmaceutical
7 ingredient and dissolution, the impact on patient care and make recommendations for action
8 from their report findings (Directive to Take Action); and be it further
9

10 RESOLVED, That our AMA advocate for legislation requiring independent testing and
11 verification of the chemical content of batches of pharmaceuticals (Directive to Take Action);
12 and be it further
13

14 RESOLVED, That our AMA advocate for the logging of batches at the patient level, so the
15 batches can be traced and connected to patient outcomes or adverse events. (Directive to Take
16 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)

1 Whereas, A 2012 national survey found that 5.9 percent of pregnant women used illicit drugs,
2 8.5 percent consumed alcohol and 15.9 percent smoked cigarettes; and
3

4 Whereas, In 2014, the prevalence of opioid use disorder in pregnant women was 6.5 per 1,000
5 births and the prevalence of neonatal abstinence syndrome (NAS) has tripled in 10 years due to
6 increasing opiate using among pregnant women in Michigan and nationally; and
7

8 Whereas, Substance use during pregnancy is considered to be child abuse in 23 states and
9 cases have been documented where women have been arrested despite voluntarily
10 participating in substance use treatment programs, which is contrary to the American Medical
11 Association's (AMA) stance on the issue (H-420.950); and
12

13 Whereas, AMA policy H-420.969 currently states that "criminal sanctions or civil liability for
14 harmful behavior by the pregnant woman toward her fetus are inappropriate;" and
15

16 Whereas, The American Academy of Pediatrics affirms that "punitive measures taken toward
17 pregnant women such as criminal prosecution and incarceration, have no proven benefits for
18 infant health," a position that was reaffirmed in 2017; and
19

20 Whereas, African American women and children have been shown to be disproportionately
21 targeted and tested 1.5 times more often than non-black women and children for substance use,
22 indicating that policies aimed at maternal substance use are being applied in a racially biased
23 manner; and
24

25 Whereas, The Supreme Court has found that involuntary drug testing of pregnant women is a
26 violation of the Fourth Amendment; and
27

28 Whereas, The Committee Opinion from the American College of Obstetricians and
29 Gynecologists encourages physicians to "retract legislation that punishes women for substance
30 abuse during pregnancy" and that legally mandated testing and reporting threatens the
31 physician-patient relationship, leading to disengagement from prenatal care; and
32

33 Whereas, The AMA opposes the criminalization of maternal drug addiction, acknowledges that
34 punishment is not an effective way to cure drug dependency or prevent future abuse, and
35 recommends treatment and education as the most effective method for reducing maternal and
36 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

- 1 RESOLVED, That our American Medical Association work with national pharmacy chains to
- 2 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)

1 Whereas, Someone in the United States needs a blood product every two seconds, yet less
2 than three percent of eligible donors will donate blood each year; and
3

4 Whereas, There are constantly blood supply shortages that deprive patients of lifesaving blood
5 products; and
6

7 Whereas, American Medical Association (AMA) policy H-50.990, "Blood Shortage and
8 Collection," calls for encouragement of blood donation to meet these increased demands and
9 prevent shortage; and
10

11 Whereas, The current Food and Drug Administration (FDA) blood donation guidelines require a
12 12-month deferral period from the most recent sexual contact with a man who has had sex with
13 another man (MSM); and
14

15 Whereas, 2.1 million potential MSM donors are unable to donate blood because of the 12-
16 month deferral, and a reduced deferral period could potentially allow 317,000 more pints of
17 blood to be collected each year; and
18

19 Whereas, Ninety percent of surveyed MSM individuals were interested in donating blood, yet
20 only five percent reported that they would remain abstinent for an entire year to be eligible to
21 donate; and
22

23 Whereas, Significant stigma still exists surrounding the 12-month deferral period in the MSM
24 community, and it is essential to establish trust in the medical community by advocating for
25 policy that is scientifically based; and
26

27 Whereas, No evidence supports the effectiveness of the current FDA 12-month deferral period,
28 and a less stigmatized approach to blood donation criteria could simultaneously maintain the
29 safety of the blood supply; and
30

31 Whereas, The Center for Disease Control and Prevention (CDC) claims nucleic acid testing
32 (NAT) for HIV, the technology currently used by blood banks, is reliable to detect HIV within 10
33 to 33 days of exposure; and
34

35 Whereas, Results from mathematical modeling studies, and empirical data from Italy, the United
36 Kingdom (UK), and Australia predict that altering Canada's MSM blood donation policy from a
37 five- to a one-year deferral would not increase the number of transfusion-transmitted HIV
38 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:

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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.
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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.
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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.
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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

1 Whereas, A community naloxone distribution and training program in Massachusetts reduced
2 opioid overdose deaths by an estimated 11 percent, without simultaneously increasing opioid
3 use, in the communities that implemented it; and
4

5 Whereas, Although 43 states in the United States and the District of Columbia have passed
6 Naloxone laws to dispense and administer the drug without a prescription, the remaining states
7 continue to have restrictions of accessibility and some still require a prescription to obtain the
8 medication; and
9

10 Whereas, There are currently 36 states where possession of naloxone without a prescription
11 may be considered a criminal offense and 15 states where naloxone dispensers do not have
12 immunity from criminal prosecution for prescribing, dispensing or distributing naloxone to a
13 layperson; and
14

15 Whereas, Restrictions to naloxone access typically question the safety of its pharmacological
16 properties and administration procedures, and the potential for higher-risk drug use practices;
17 however, available data suggests that these concerns are largely unfounded, and that any
18 potential risks are outweighed by benefits; therefore be it
19

20 RESOLVED, That our American Medical Association support the legal access to and use of
21 naloxone in all public spaces regardless of whether the individual holds a prescription (New
22 HOD Policy); and be it further
23

24 RESOLVED, That our AMA amend Policy H-95.932, "Increasing Availability of Naloxone," by
25 addition and deletion as follows:
26

27 1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase
28 access to affordable naloxone, including but not limited to collaborative practice
29 agreements with pharmacists and standing orders for pharmacies and, where permitted
30 by law, community-based organizations, law enforcement agencies, correctional
31 settings, schools, and other locations that do not restrict the route of administration for
32 naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies
33 to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe
34 naloxone to patients at risk of overdose and, where permitted by law, to the friends and
35 family members of such patients. 4. Our AMA encourages private and public payers to
36 include all forms of naloxone on their preferred drug lists and formularies with minimal
37 or no cost sharing. 5. Our AMA supports liability protections for physicians and other
38 health care professionals and others who are authorized to prescribe, dispense and/or
39 administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage
40 individuals who are authorized to administer naloxone to receive appropriate education
41 to enable them to do so effectively. 7. Our AMA encourages manufacturers or other
42 qualified sponsors to pursue the application process for over the counter approval of
43 naloxone with the Food and Drug Administration. 8. Our AMA ~~urges the Food and Drug~~
44 ~~Administration to study the practicality and utility of~~ supports the widespread
45 implementation of easily accessible Naloxone rescue stations (public availability of
46 Naloxone through wall-mounted display/storage units that also include instructions)
47 throughout the country following distribution and legislative edicts similar to those for
48 Automated External Defibrillators. (Modify Current HOD Policy)

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

Received: 05/09/19

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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-utero¹; and

Whereas, The prevalence of opioid use disorder in pregnant women quadrupled from 1994 to 2014 to 6.5 per 1,000 births²; 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 hospitals¹; 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 cases⁴; 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 beds⁵⁻⁶; and

Whereas, Patients with NAS are hyperarousable with altered sleep/wake states and thus require a dark, quiet environment and minimal stimulation⁷; 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 not⁸⁻⁹; 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 child¹⁰⁻¹¹; 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,

1 and lowered cost by 75% without a significant difference in readmission rates or adverse in-
2 hospital events^{1,9,11,12}; and

3
4 Whereas, Rooming-in has been noted to have the additional benefits of increasing parental
5 involvement and breastfeeding^{9,12}; and

6
7 Whereas, Bonding and attachment aided by the release of oxytocin during breastfeeding may
8 protect the mother against addiction relapse and stress, and breastfeeding can prevent or
9 reduce complications of NAS so infants demonstrate lower NAS scores, need less
10 pharmacological treatment, and have a shorter LOS¹³⁻¹⁵; and

11
12 Whereas, Maximum parental presence (100%) was associated with a 9-day shorter LOS and 8
13 fewer days of infant opioid therapy as well as fewer days of infant opioid therapy and reduced
14 mean NAS score after adjusting for breastfeeding¹⁶; and

15
16 Whereas, The AAP Committee on Fetus and Newborn found that rooming-in provides more
17 security for healthy term newborns, increases supervised maternal-newborn interactions, and
18 more opportunities for hospital staff to empower parents to care for their infants¹⁷; therefore be it

19
20 RESOLVED, That our American Medical Association support keeping patients with neonatal
21 abstinence syndrome with their parents or legal guardians in the hospital throughout their
22 treatment, as the patient's health and safety permits, through the implementation of rooming-in
23 programs (New HOD Policy); and be it further

24
25 RESOLVED, That our AMA support the education of physicians about rooming-in patients with
26 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)

1 Whereas, Trauma is defined by the Substance Abuse and Mental Health Services
2 Administration (SAMHSA) as “an event, series of events, or set of circumstances that is
3 experienced by an individual as physically or emotionally harmful or life threatening and that has
4 lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or
5 spiritual well-being”¹⁻⁴; and

6
7 Whereas, Over two-thirds of Americans are exposed to at least one traumatic event by the age
8 of 16 and each additional traumatic event increases the risk of an adverse health outcome
9 proportionally^{1,3,5,6}; and

10
11 Whereas, Trauma’s lasting health implications cause economic impacts, with estimates of just
12 child maltreatment costing the US economy \$124 billion per year⁷; and

13
14 Whereas, Physicians and other health care providers can mitigate trauma-induced adverse
15 health outcomes, such as chronic disease and risky health behaviors, by practicing trauma-
16 informed care^{1,3,6}; and

17
18 Whereas, Trauma-informed care is the recognition of trauma’s impact on patients’ lives,
19 identification of signs of trauma, creation of safe, transparent, and supportive environments, and
20 avoidance of re-traumatization⁴; and

21
22 Whereas, Many states and cities have attempted to address trauma and treatment in their
23 communities by collecting data, training health care providers, and providing resources^{8,9,10,11};
24 and

25
26 Whereas, Several prominent national organizations, such as the Centers for Disease Control
27 and Prevention (CDC), SAMHSA, the National Child Traumatic Stress Network (NCTSN), and
28 the National Council, have conducted research and created trauma-informed care training
29 tools^{12,13,14,15}; and

30
31 Whereas, There also exist several evidence-based school-based trauma-informed care
32 interventions that have been shown to be effective in addressing trauma, resulting in decreased
33 trauma-related symptoms, reduced PTSD scores, improved grades, and drops in disciplinary
34 office referrals and suspensions¹⁶⁻²³; and

35
36 Whereas, Despite this evidence, trauma-informed services within schools have only
37 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 populations¹⁶; 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)

1 Whereas, Injury is the leading cause of death for people under the age of 44 in the United
2 States and severe bleeding accounts for greater than 33 percent of prehospital trauma
3 deaths^{1,2}; and
4

5 Whereas, The most significant preventable cause of death in the prehospital environment is
6 external hemorrhage³; and
7

8 Whereas, Bystanders play an important role in bleeding control as average national emergency
9 medical services (EMS) response times are longer than the time it can take for individuals to die
10 from exsanguination⁴; and
11

12 Whereas, As of 2018, over 124,000 members of the general public have been trained in basic
13 bleeding control techniques by the Stop the Bleed Campaign⁵; and
14

15 Whereas, Civilian prehospital tourniquet application is independently associated with a 6-fold
16 mortality reduction in patients with peripheral vascular injuries⁶; and
17

18 Whereas, The Occupational Safety and Health Administration (OSHA) standards govern
19 requirements that must be followed by private sector and federal workers⁷; and
20

21 Whereas, OSHA Appendix A to Standard 1910.151 cites (ANSI) Z308.1-1998 as an example of
22 a workplace first aid kit, but this does not reflect that the standard for such kits was updated in
23 2015 to include more comprehensive hemostatic supplies, including a tourniquet^{8,9}; and
24

25 Whereas, OSHA standards for industries such as logging explicitly mandate the “minimally
26 acceptable number and type of first-aid supplies for first-aid kits”, but these requirements do not
27 directly reflect the (ANSI) Z308.1-2015 standard¹⁰; and
28

29 Whereas, Trained bystanders should have immediate access to updated and appropriate
30 bleeding control supplies, such as a tourniquet and hemostatic gauze, to be most effective in
31 controlling life-threatening bleeding³; and
32

33 Whereas, Our AMA previously passed policy which supports the widespread placement of
34 AEDs in schools and other public places (H-130.935, D 470.992); therefore be it

1 RESOLVED, That American Medical Association Policy H-130.935, "Support for Hemorrhage
2 Control Training," be amended by addition to read as follows:

3
4 H-130.935 Support for Hemorrhage Control Training

5 1. Our AMA encourages state medical and specialty societies to promote the
6 training of both lay public and professional responders in essential techniques of
7 bleeding control.

8 2. Our AMA encourages, through state medical and specialty societies, the
9 inclusion of hemorrhage control kits (including pressure bandages, hemostatic
10 dressings, tourniquets and gloves) for all first responders.

11 3. Our AMA supports the increased availability of bleeding control supplies in
12 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 material¹; 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 group²; 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 work³; and

Whereas, The Kinsey Institute survey found that 9% of porn viewers reported that they had tried unsuccessfully to stop³; 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 serotonergic neurotransmitter dysregulation similar to that of addictive disorders^{4,5}; and

Whereas, A number of studies have linked problematic pornography use to increased incidence of erectile dysfunction⁶ and higher rates of domestic violence⁷⁻⁹; 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 publication¹; 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

References:

1. Doring, N. M. The internet's impact on sexuality: A critical review of 15 years of research. *Computers in Human Behavior*. 2009;25(5):1089-1101.
2. Bóthe, B., Tóth-Király, I., Zsila, Á., Griffiths, M. D., Demetrovics, Z., & Orosz, G. (2018). The development of the problematic pornography consumption scale (PPCS). *The Journal of Sex Research*. 2018;55(3):395-406.
3. Weir, K. (2014). Is pornography addictive? *American Psychological Association*. 2014: 45(4):46.
4. Voon, V., et al. Neural correlates of sexual cue reactivity in individuals with and without compulsive sexual behaviours. *Plos One*. 2014;9(7):e102419.
5. Gola, M., et al. Can pornography be addictive? An fMRI study of men seeking treatment for problematic pornography use. *Biorxiv*. 2017.
6. Foubert, J. D. (2017). The public health harms of pornography: The brain, erectile dysfunction, and sexual violence. *Dignity: A Journal on Sexual Exploitation and Violence*. 2(3). <http://digitalcommons.uri.edu/dignity/vol2/iss3/6> Published July 12, 2017. Accessed April 3, 2018.
7. Janet, H. S. When words are not enough: The search for the effect of pornography on abused women. *Violence Against Women*. 2004: 10(1), 56-72.
8. Romito, P., & Beltramini, L. Watching pornography: Gender differences, violence and victimization. an exploratory study in Italy. *Violence Against Women*. 2011: 17(10), 1313-1326.
9. Simmons, C. A., Lehmann, P., & Shannon Collier-Tenison. Linking male use of the sex industry to controlling behaviors in violent relationships: An exploratory analysis. *Violence Against Women*. 2008: 14(4):406-417.

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 cause¹⁻³; 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 office⁴⁻⁶; 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

1 RESOLVED, That our American Medical Association urge the Environmental Protection Agency and
2 other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use
3 pesticides, that safeguard human and environmental health, especially in vulnerable populations
4 including but not limited to agricultural workers, immigrant migrant workers, and children (Directive to
5 Take Action); and be it further

6
7 RESOLVED, That our AMA analyze ongoing regulation delays that impact public health, as
8 deemed appropriate. (Directive to Take Action)

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

Received: 05/09/19

References:

1. Public Affairs. Laws & Regulations. HHS.gov. <https://www.hhs.gov/regulations/index.html>. Published March 18, 2016. Accessed September 17, 2018.
2. Public Health Professionals Gateway. Centers for Disease Control and Prevention. <https://www.cdc.gov/stltpublichealth/policy/legislation-regulation-policies.html>. Published November 9, 2015. Accessed September 17, 2018.
3. Federal Register Tutorial. National Archives and Records Administration. <https://www.archives.gov/federal-register/tutorial/online-html.html>. Accessed September 17, 2018.
4. Sherwin RP. Commentary: What Is an Adverse Health Effect? Environmental Health Perspectives. 1983;52:177-182. doi:10.2307/3429667
5. McQuaid J. Make America Wait Again: Trump Tries to Delay Regulations out of Existence. Scientific American. <https://www.scientificamerican.com/article/make-america-wait-again-trump-tries-to-delay-regulations-out-of-existence/> Published July 24, 2017. Accessed September 17, 2018.
6. 2017 Trump Administration Regulatory Freeze Memo to Agency Heads. NAFSA: Association of International Educators. https://www.nafsa.org/Professional_Resources/Browse_by_Interest/International_Students_and_Scholars/2017_Trump_Administration_Regulatory_Freeze_Memo_to_Agency_Heads/. Accessed September 17, 2018.

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 administration;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.
4. UT Staff. "UT to Offer Free Narcan Training ." UT News, utnews.utoledo.edu/index.php/06_11_2018/ut-to-offer-free-narcan-training-june-19.
5. New York Medical College. "NYMC and Westchester DOH Collaborate to Combat Opioid Overdoses." New York Medical College, www.nymc.edu/news-and-events/news-archives/2016/combating-opioid-overdoses/.
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.
8. McClellan, Chandler, et al. "Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality." NeuroImage, Academic Press, 19 Mar. 2018, www.sciencedirect.com/science/article/pii/S0306460318301382.
9. Kerensky, Todd, and Alexander Y. Walley. "Opioid Overdose Prevention and Naloxone Rescue Kits: What We Know and What We Don't Know." Addiction Science & Clinical Practice 12 (2017): 4. PMC. Web. 24 Sept. 2018.
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

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)

1 Whereas, Healthcare in the United States is being largely managed and reshaped by hospital
2 administrators, consultants and politicians, with relatively little substantive input from physicians;
3 and
4

5 Whereas, Physicians who care for patients understand better than anyone the ways in which
6 our healthcare system is broken and needs to be improved; and
7

8 Whereas, Dysfunction of our healthcare system and lack of opportunities for physicians to have
9 a meaningful voice in bringing about needed changes, are significant contributing factors to
10 physician dissatisfaction, frustration and burnout; and
11

12 Whereas, Physicians are disadvantaged by the lack of easily available education in health
13 policy and health law, essential skills for navigating barriers and effecting change; and
14

15 Whereas, Existing fellowships in health policy and health law offered by outside organizations
16 tend to promote the values and priorities of those organizations; therefore be it
17

18 RESOLVED, That our American Medical Association offer its members training in health policy
19 and health law, and develop a fellowship in health policy and health law. (Directive to Take
20 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)

1 Whereas, The U.S. population's linguistic demographics continue to diversify with over 350
2 languages spoken in the U.S.;¹ and
3

4 Whereas, Population estimates regarding individuals with limited English proficiency (LEP)
5 suggest there are over 25 million people with LEP in the U.S., the majority (64%) of whom are
6 Spanish speakers,²⁻³ and with substantial additional population who may not have general LEP
7 but may have difficulty communicating in English during medical encounters due to the
8 complexity of health-related cultural-linguistic elements, illness-related stressors, and other
9 concomitant access-to-care challenges in minority populations;⁴⁻⁶ and
10

11 Whereas, The federal government mandates that health care be provided equitably to patients
12 in their preferred language regardless of national origin or language preference;⁷⁻⁸ and
13

14 Whereas, Data demonstrates that language concordance, defined as direct patient-physician
15 communication in the same language, improves patient outcomes and satisfaction;⁹⁻¹¹ and
16

17 Whereas, Data demonstrates that language concordant care is superior to professional
18 interpreter-mediated medical care;¹²⁻¹³ and
19

20 Whereas, A majority of medical schools report offering opportunities for linguistic education for
21 medical students in languages other than English (e.g. medical Spanish) due to patient
22 population demographic needs and increasing student demand;¹⁷ and
23

24 Whereas The long-term outcomes of medical school education in non-English medical
25 communication skills, such as appropriate interpreter use,¹⁸⁻¹⁹ cultural competency, and
26 linguistic training (e.g., medical Spanish)²⁰ are currently unknown and would require collection
27 and evaluation of physician language proficiency data; and
28

29 Whereas, Existing language concordance preliminary data of primary care providers' languages
30 conducted in California demonstrates a gross language concordance mismatch compared to the
31 regional population linguistic profile,²¹ and conducting similar studies locally, regionally, and
32 nationally would enable a needs assessment of available physician resources with regards to
33 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 patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

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

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

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

(b) Avoid stereotyping patients.

(c) Examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.

(d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.

(e) Encourage shared decision making.

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

The medical profession has an ethical responsibility to:

(g) Help increase awareness of health care disparities.

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

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

[AMA Principles of Medical Ethics: I, IV, VII, VIII, IX](#)

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 demographics⁴; 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

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-u-s>. 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

- 1 RESOLVED, That our American Medical Association develop a plan with input from the Minority
- 2 Affairs Section and the Chief Health Equity Officer to consistently include racial and ethnic
- 3 minority demographic information for physicians and medical students. (Directive to Take
- 4 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 agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty 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 events¹; 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-135.938²; 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 care³; 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 AMA⁵; 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

- 1 RESOLVED, That our American Medical Association change existing automatic paper *JAMA*
2 subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to
3 receive paper *JAMA*, in order to support broader climate change efforts. (Directive to Take
4 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)

1 Whereas, TIME'S UP was established in response to the common experience of power inequity
2 and unsafe workplaces for women and other underrepresented groups everywhere, women in
3 healthcare took notice; and
4

5 Whereas, TIME'S UP launched one year ago, women from across industries have come
6 together to address systemic inequality and injustice in the workplace; and
7

8 Whereas, The TIME'S UP Healthcare initiative (<https://www.timesuphealthcare.org>) launched on
9 February 28, 2019; and
10

11 Whereas, TIME'S UP Healthcare is a non-profit initiative of the Time's Up Foundation, which
12 insists on safe, fair and dignified work for women in all healthcare settings; and
13

14 Whereas, The mission of TIME'S UP Healthcare is to unite national efforts to bring equity,
15 inclusion and safety to the healthcare industry; and
16

17 Whereas The TIME'S UP raises awareness and knowledge about inequity and harassment and
18 their effect on healthcare; and
19

20 Whereas, TIME'S UP Healthcare is adding its voice to that effort and calling for systemic
21 change in the workplace culture in healthcare; and
22

23 Whereas, Although women make up over 80% of the healthcare workforce, the decision
24 makers, including hospital leadership, executives and association presidents, are largely men;
25 and
26

27 Whereas, Physicians continue to work in environments highly tolerant of gender-based
28 harassment; and
29

30 Whereas, Gender-based harassment undermines women's professional and educational
31 attainment and mental and physical health; and
32

33 Whereas, Gender-based harassment has negative effects of psychological well-being; and
34

35 Whereas, At the 2018 Annual Meeting of the American Medical Association House of
36 Delegates, powerful testimony was delivered about the experiences of members and staff who
37 have experienced harassment at AMA meetings and facilities; and

1 Whereas, The Board of Trustees responded to the will of the House to enact policies that will
2 decrease the likelihood of gender-based harassment experienced by AMA staff or members;
3 and
4

5 Whereas, TIME'S UP "partners" are organizations and societies/associations that have the
6 ability to work to develop policies and education to transmit to their members; and
7

8 Whereas, TIME'S UP partners (as of March 8, 2019) include American College of Physicians,
9 American Nurses Association, American Medical Women's Association, Council of Medical
10 Specialty Societies, National Medical Association, and Service Employees International Union
11 (SEIU); and
12

13 Whereas, TIME'S UP partners pledge their commitment to and alignment with TIME'S UP
14 Healthcare core statements confirming:
15

- 16 - that sexual harassment and gender inequity have no place in the healthcare workplace;
- 17 - that we are committed to preventing sexual harassment and gender inequity and
18 protecting and aiding those who are targets of harassment and discrimination;
- 19 - that we believe every employee should have equitable opportunity, support, and
20 compensation;
- 21 - that we cannot address a problem without understanding its scope and impact;
- 22 - that we will measure and track sexual harassment and gender-based inequities occurring
23 in our institution; and
24

25 Whereas, The process is not associated with a fee and takes less than two minutes to complete
26 the electronic form on the TIME's UP Healthcare website; and
27

28 Whereas, By becoming a TIME'S UP partner, our American Medical Association would publicly
29 demonstrate our commitment to strengthen the structures, processes, and outcomes that will
30 allow us to achieve safe, dignified, and equitable workplace and environment; therefore be it
31

32 RESOLVED, That our American Medical Association evaluate TIME'S UP Healthcare program
33 and consider participation as a TIME'S UP partner in support of our mutual objectives to
34 eliminate harassment and discrimination in medicine with report back at the 2019 Interim
35 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)

1 Whereas, Physicians with disabilities can be stigmatized, marginalized in society as a whole
2 and within the medical community; and
3

4 Whereas, Physicians with disabilities can provide valuable services not only to patients, but also
5 to their practices and the community of medicine; and
6

7 Whereas, Physicians with disabilities have specific legal rights to accommodation and absence
8 of discrimination of which they may not be aware; and
9

10 Whereas, Physicians with disabilities may experience profound social, cultural and economic
11 disadvantage and exclusion; and
12

13 Whereas, Promoting progressive removal of barriers to the full and effective participation of
14 persons with disabilities in all aspects of development, and promoting the equal enjoyment by
15 persons with disabilities of civil, political, economic, social and cultural rights will further the
16 equalization of opportunities and contribute to the realization of a "society for all" in the twenty-
17 first century; and
18

19 Whereas, Disabled physicians would benefit from the identification of support groups, resources
20 for retraining, opportunities to work with medical students, residents and physicians in practice
21 as well as all other resources to facilitate their inclusion in the medical community; therefore be
22 it
23

24 RESOLVED That our American Medical Association study and report back on eliminating
25 stigmatization and enhancing inclusion of disabled physicians including but not limited to:
26

27 1) Enhancing representation of disabled physicians within the AMA.
28

29 2) Examining support groups, education, legal resources and any other means to
30 increase the inclusion of physicians with disabilities in the AMA (Directive to Take
31 Action); and be it further
32

33 RESOLVED That our AMA identify medical, professional and social rehabilitation, education,
34 vocational training and rehabilitation, aid, counseling, placement services and other services
35 which will enable disabled physicians to develop their capabilities and skills to the maximum and
36 will hasten the processes of their social and professional integration or reintegration. (Directive
37 to Take Action)

Fiscal Note: Not yet determined

Received: 05/09/19

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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](#)
11. Meeks LM, Herzer KR. Accommodated MCAT time and performance measurements. *JAMA*. 2015;314(14):1517-1518.[ArticlePubMedGoogle ScholarCrossref](#)
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/nondallianceroindentablereport.pdf>

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

- 1 RESOLVED, That our AMA ask CMS to refrain from issuing citations or imposing financial
- 2 penalties for the medically necessary and appropriate use of antipsychotic medication for the
- 3 treatment of dementia-related psychosis. (Directive to Take Action)

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

Received: 05/09/19

Reference:

Treatment of Depression in Older Adults Evidence-Based Practices (EBP) Kit <http://store.samhsa.gov/product/Treatment-of-Depression-in-OlderAdults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD> Blueprint for Change: Achieving Integrated Health Care for an Aging Population <http://www.apa.org/pi/aging/programs/integrated/integratedhealthcare-report.pdf> Integrated Health Care for an Aging Population- Fact Sheet <http://www.apa.org/pi/aging/programs/integrated/ihap-factsheetpolicymakers.pdf>

Madhusoodanan S, Brenner R. Caring for the Chronically Mentally ill in Nursing homes. Annals of Long-Term Care. 2007; 15(9)

[1] The long-term mental health care for people with severe mental disorders. J.M Caldas de Almeida, H. Killaspy. Prepared under service contract with the Impact Consortium by the European Commission. 2011.

http://ec.europa.eu/health/mental_health/docs/healthcare_mental_disorders_en.pdf

(SAMHSA [https://www.integration.samhsa.gov/about-](https://www.integration.samhsa.gov/about-us/Aging_Well_Addressing_Behavioral_Health_with_Older_Adults_in_Primary_Care_Settings.pdf)

[us/Aging_Well_Addressing_Behavioral_Health_with_Older_Adults_in_Primary_Care_Settings.pdf](https://www.integration.samhsa.gov/about-us/Aging_Well_Addressing_Behavioral_Health_with_Older_Adults_in_Primary_Care_Settings.pdf)

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

1 contractual provisions that would limit the services offered, restrict referral or treatment
2 options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d)
3 medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G,
4 Rec. 2, A-96; Reaffirmation A-97)

5
6 (2) Conduct of Review. Our AMA ~~supports~~ advocate for the development of additional draft
7 state and federal legislation to: (a) require private review entities and payers to disclose to
8 physicians on request the screening criteria, weighting elements and computer algorithms
9 utilized in the review process, and how they were developed; (b) require that any physician
10 who recommends a denial as to the medical necessity of services on behalf of a utilization
11 review entity or health plan be of the same specialty and have expertise to treat the medical
12 condition or disease as the practitioner who provided the services under review; (c) Require
13 every organization that reviews or contracts for review of the medical necessity of services
14 to establish a procedure whereby a physician claimant has an opportunity to appeal a claim
15 denied for lack of medical necessity to a medical consultant or peer review group which is
16 independent of the organization conducting or contracting for the initial review; (d) require
17 that any physician who makes judgments or recommendations regarding the necessity or
18 appropriateness of services or site of service be licensed to practice medicine in the same
19 jurisdiction as the practitioner who is proposing the service or whose services are being
20 reviewed; (e) require that review entities respond within 48 hours to patient or physician
21 requests for prior authorization, and that they have personnel available by telephone the
22 same business day who are qualified to respond to other concerns or questions regarding
23 medical necessity of services, including determinations about the certification of continued
24 length of stay; (f) require that any payer instituting prior authorization requirements as a
25 condition for plan coverage provide enrollees subject to such requirements with consent
26 forms for release of medical information for utilization review purposes, to be executed by
27 the enrollee at the time services requiring such prior authorization are recommended or
28 proposed by the physician; and (g) require that payers compensate physicians for those
29 efforts involved in complying with utilization review requirements that are more costly,
30 complex and time consuming than the completion of standard health insurance claim forms.
31 Compensation should be provided in situations such as obtaining preadmission certification,
32 second opinions on elective surgery, and certification for extended length of stay.

33
34 (3) Accountability. Our AMA believes that draft federal and state legislation should also be
35 developed to impose similar liability on health benefit plans for any harm to enrollees
36 resulting from failure to disclose prior to enrollment the information on plan provisions and
37 operation specified under Section 1 (a)-(d) above. (Modify HOD Policy); and be it further
38

39 RESOLVED, That the AMA and its Council on Judicial and Ethical Affairs, study the ethical and
40 medicolegal responsibilities of physicians who participate in the prior authorization process on
41 behalf of utilization review entities or health plans, particularly with regard to determinations of
42 medical necessity, and report back to the HOD at the 2020 Annual Meeting with guidance for
43 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)

1 Whereas, The Council for Affordable Quality Healthcare (CAQH) is a single data repository
2 which maintains information about physicians for credentialing; and
3

4 Whereas, Physicians are being asked to resubmit their data every 120 days to maintain
5 credentialing on this site even if none of the relevant information has changed; and
6

7 Whereas, Resubmission requires actual data submission, not just confirmation of existing data;
8 and
9

10 Whereas, Even confirmation of existing data should not require verification every 90 to 120
11 days; and
12

13 Whereas, Confirmation of data every 120 days is not an industry standard for any similar
14 credentialing process, such as for third party payers or for hospital medical staff requirements;
15 and
16

17 Whereas, The need to continue this process places an unnecessary burden on physicians
18 without any clear indication for this ongoing request; therefore be it
19

20 RESOLVED, That our American Medical Association work with the Council for Affordable
21 Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of
22 required CAQH reporting to twelve months or longer unless the physician has a change in
23 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