

Reference Committee E

CSAPH Report(s)

01 CSAPH Sunset Review of 2009 House of Delegates Policies

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-19

Subject: CSAPH Sunset Review of 2009 House of Delegates Policies

Presented by: Robyn F. Chatman, MD, MPH, Chair

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

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

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

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

(1) As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years. (2) In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.

1 In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on
2 the disposition of the HOD policies from 2009 that were assigned to it. The CSAPH's
3 recommendations on policies are presented in the Appendix to this report.
4

5 RECOMMENDATION
6

7 The Council on Science and Public Health recommends that the House of Delegates policies listed
8 in the Appendix to this report be acted upon in the manner indicated and the remainder of the
9 report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX: Recommended Actions on 2009 House Policies and Directives

Number	Title	Recommended Action and Rationale
D-100.974	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Rescind. Accomplished.
D-130.968	Standards of Care During a Mass Casualty Event	<p>Retain in part to read as follows and change to an H-policy:</p> <p>1. Our American Medical Association acknowledges that, in a mass casualty event, adjustments in the current health and medical care standards may be necessary to ensure that the care provided results in saving as many lives as possible.</p> <p>2. Our AMA will: (a) continue to participate with relevant stakeholders to develop and disseminate guidance on the issue of the appropriate standard of care in a mass casualty event; (b) encourage state and specialty medical societies to work with state departments of health and other stakeholders as they develop guidance on allocating scarce resources and establishing the standard of care; and (c) encourage the creation of an adequate legal framework at the local, state, and federal levels for providing health and medical care in a mass casualty situation.</p> <p>Citation: (BOT Rep. 2, I-09)</p>
D-135.982	Regulation of Endocrine Disrupting Chemicals	Retain and change to H-policy.
D-135.983	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Rescind. Include the specific standards outlined in this directive to H-135.946, "Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)".
D-150.979	Appropriate Supplementation of Vitamin D	<p>Retain in part to read as follows and change to an H-policy: Our AMA:</p> <p>1. supports continued research on vitamin D and its metabolites, particularly long-term studies that address the benefits, adverse outcomes, and potential confounders across all life stage groups;</p> <p>2. will educate physicians about the evolving science of vitamin D and its impact on health and develop resources about vitamin D for patients;</p> <p>3. encourages physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status; and</p> <p>4. will monitor the development of new dietary references intakes for vitamin D in 2010 and respond as appropriate.</p>

Number	Title	Recommended Action and Rationale
D-350.990	Next Steps Following AMA Apology to African American Physicians	Retain in part to read as follows and change the title to more accurately represent the language in the policy: Next Steps Following AMA Apology to African American Physicians <u>Collaboration with the National Medical Association to Address Health Disparities</u> Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support the Commission to End Health Care Disparities efforts to increase the cultural competence of clinicians, and reduce health disparities. Citation: (BOT Action in response to referred for decision Res. 606, A-09)
D-440.995	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Rescind. Accomplished.
D-450.968	Best Practices for Patients with Chronic Diseases	Rescind. Accomplished.
D-460.990	Science, Policy Implications, and Current AMA Position Regarding Embryonic/Pluripotent Stem Cell Research and Funding	Retain. Still relevant.
D-460.993	Support of Embryonic Stem Cell Research	Retain with change in title. Convert to an H policy. <u>Support of Embryonic/Pluripotent Stem Cell Research</u>
D-460.996	Medical Genetics	Retain. Still relevant.
D-460.999	Support for Upgrading and Expanding Medical Research Facilities	Rescind. Accomplished by 42 USC 283k(c)2.
D-480.979	Ultrasound Contrast Agents	Retain. Still relevant.
D-515.982	Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse	Retain. Still relevant.
D-60.973	Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths	Retain in part to read as follows: 1. Our AMA will advocate for a ban on the marketing of products such as <u>flavored malt liquor beverages</u> aleopops , gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age. 2. Our AMA supports state and federal regulations that would reclassify Aleopops <u>flavored malt liquor</u>

Number	Title	Recommended Action and Rationale
		<u>beverages</u> as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.
D-95.996	Consensus Statement of the Physician Leadership on National Drug Policy	Retain in part to read as follows and change to an H-policy: Our AMA endorses <u>supports</u> the 1997 Consensus Statement of the Physicians <u>and Lawyers for Leadership</u> on National Drug Policy as a rational approach to informing national drug policy on illegal drugs.
D-95.997	Altered Illicit Substances	Retain. Still relevant.
D-95.999	Reduction of Medical and Public Health Consequences of Drug Abuse: Update	Retain. Still relevant.
H-10.968	Public Health Impact on Railroads	Retain. Still relevant.
H-100.962	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Retain. Still relevant.
H-100.969	Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals	Retain. Still relevant.
H-125.989	Opposition to Payment for Prescription-Switching	Retain. Still relevant.
H-135.941	Air Pollution and Public Health	Retain. Still relevant.
H-135.946	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Retain with the addition of the specific standards included in D-135.983, "Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)." Our AMA supports more stringent air quality standards for particulate matter than those proposed by the EPA Administrator. This position is supported by several medical specialty societies. We specifically request a <u>NAAQS that provides improved protection for our patients which includes:</u> - 12 µg/m ³ for the average annual standard - 25 µg/m ³ for the 24-hour standard - 99th percentile used for compliance determination
H-135.979	Clean Air	Retain. Still relevant.
H-145.979	Prevention of Unintentional Shooting Deaths Among Children	Retain. Still relevant.
H-15.958	Fatigue, Sleep Disorders, and Motor Vehicle Crashes	Retain in part to read as follows: Our AMA: (1) defines <u>recognizes</u> sleepiness behind the wheel as a major public health issue and <u>continues to</u> encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

Number	Title	Recommended Action and Rationale
		<p>(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.</p> <p>(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.</p> <p>(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness-testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.</p> <p>(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.</p> <p>(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.</p> <p>(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.</p> <p>(8) recommends that <u>states adopt regulations</u> guidelines be developed for the licensing of commercial and private drivers with sleep-related and other medical</p>

Number	Title	Recommended Action and Rationale
		<p>disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.</p> <p>(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.</p> <p>Citation: (CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09)</p>
H-15.999	Automobile Safety Standards	Retain. Still relevant.
H-150.945	Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants	Retain. Still relevant.
H-150.952	Point-of-Sale Warning Signs Regarding Consumption of Raw Shellfish	Retain. Still relevant.
H-160.928	Drug Initiation or Modification by Pharmacists	Retain. Still relevant.
H-160.938	Disease-Specific Self-Management Programs	Retain. Still relevant.
H-170.962	An Updated Review of Sex Education Programs in the United States	Rescind. Covered by H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools".
H-170.977	Comprehensive Health Education	<p>Retain in part to read as follows:</p> <p>(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades <u>pre</u> - kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug <u>misuse</u> abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol <u>misuse</u> abuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended</p>

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		pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribed amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
H-20.896	Support of a National HIV/AIDS Strategy	Retain in part to read as follows: Our AMA supports the creation of a National HIV/AIDS strategy, and will work with the White House Office of National AIDS Policy, the Coalition for a National HIV/AIDS Strategy, and other relevant stakeholders <u>bodies to develop a update and implement the National HIV/AIDS strategy.</u>
H-245.973	Standardization of Newborn Screening Programs	Retain. Still relevant.
H-250.989	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Retain with a change in title. Screening Nonimmigrant Visitors to the United States for <u>Global Tuberculosis Control</u>
H-280.952	CMS Interim Final Rule on the Use of Seclusion and Restraints	Retain. Still relevant.
H-280.959	Recycling of Nursing Home Drugs	Retain. Still relevant.
H-345.999	Statement of Principles on Mental Health	Retain in part to read as follows: (1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed patients with psychiatric illness , but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental <u>psychiatric</u> illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive. (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of

Number	Title	Recommended Action and Rationale
		<p>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.</p> <p>(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.</p> <p>(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.</p>
H-350.958	Hispanic Population and Access to the US Healthcare System	Rescind. Policy H-160.931 Part 2 covers this topic.
H-350.959	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	Rescind. This policy adopted the guiding principles of the Commission to End Health Care Disparities. Since the Commission no longer exists, it does not make sense to keep a policy that references their guiding principles.
H-420.971	Infant Victims of Substance Abuse	Retain. Still relevant.
H-420.974	Warnings Against Alcohol Use During Pregnancy	Retain. Still relevant.
H-440.857	Placement of Alcohol-Based Hand Sanitizer Dispensers in Highly Trafficked Areas	Retain. Still relevant.
H-440.858	Disease Transmission Via Foods: Public Health Disaster in Waiting	Retain. Still relevant.
H-440.927	Tuberculosis	<p>Retain in part to read as follows with a change in title:</p> <p><u>Tuberculosis Control Measures</u></p> <p>Public Health Policy, Compliance and Coercion: The AMA: (1) supports <u>state and local health authorities'</u> the initiative of public health authorities to modernize the health codes of their states on tuberculosis (TB) control programs, including specific authorization for implementation of control orders a Commissioner-ordered program of directly observed therapy for tuberculosis when patient compliance poses a risk to the public;</p> <p>(2) supports the view that directly observed therapy for tuberculosis TB <u>TB</u> for newly discharged patients from hospitals is seen as desirable routine policy for community control against the evolution of multi-drug resistant strains;</p> <p>(3) supports the view that, <u>recognizes in cases where</u></p>

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		<p>when coercive examination, evaluation, treatment or detention are deemed seen as necessary by public health authorities, each decision should be individualized and subject to due process; and</p> <p>(4) recognizes that the control of tuberculosis (TB) in the foreign-born population is critical to the elimination of TB in the United States, and supports current Centers for Disease Control and Prevention (CDC) recommendations on the prevention and control of TB among foreign-born persons.</p>
H-440.958	Universal Immunization for Hepatitis B Virus	<p>Retain in part to read as follows:</p> <p>For enhanced effectiveness in decreasing the incidence of hepatitis B in the United States, it appears to be necessary to broaden current immunization strategies. Safe and effective vaccines are available for prevention of the disease but this use is limited by cost. Eradication of the disease on a national and international basis is a definite hope, but may not be possible without the development of antiviral treatments to control or eliminate the virus in the carrier state and in infected vaccine nonresponders. Education about the disease and its transmission is an essential element for any effective program to reduce the incidence of hepatitis B. Therefore,</p> <p>(1) The AMA supports endorses the principle of the universal immunization with hepatitis B vaccine of all infants, adolescents, military recruits, and students entering colleges and technical schools. While the ultimate goal is the complete immunization of all these groups, the process will need to be a gradual one beginning with the immunization of high risk groups and then the phasing in of infants, adolescents, and the other groups. the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B.</p> <p>(2) The AMA encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition.</p> <p>(3) The Association supports the immunization of all other risk groups with special emphasis on patients attending sexually transmitted disease clinics and drug rehabilitation centers.</p> <p>(4) (3) The AMA Association supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection.</p> <p>(5) (4) The AMA Association encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators</p>

Number	Title	Recommended Action and Rationale
		and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation. (6) The Association encourages the scientific community to intensify its efforts to find effective therapies for patients infected with hepatitis B virus. (7) (5) The AMA Association encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.
H-440.983	Update on Sexually Transmitted Infections	Retain. Still relevant.
H-45.977	Flu Protection Guidelines for Air Travel	Retain. Still relevant.
H-45.983	Medical Oxygen Therapy on Scheduled Commercial Air Service	Retain. Still relevant.
H-45.997	In-Flight Emergency Care	Retain. Still relevant.
H-450.952	Regional Input Into the Accreditation Process	Retain. Still relevant.
H-460.920	Public Access to Unpublished Research Data	Retain. Still relevant.
H-460.971	Support for Training of Biomedical Scientists and Health Care Researchers	Retain. Still relevant.
H-460.976	Congressional Earmarking of Federal Research Funds	Retain. Still relevant.
H-460.977	Proposed Moratorium on New Animal Patents	Retain. Still relevant.
H-460.994	Support for Careers in Research	Retain. Still relevant.
H-460.995	Support for Careers in Research	Retain. Still relevant.
H-470.962	Cardiovascular Preparticipation Screening of Student Athletes	Retain. Still relevant.
H-470.973	Boxing as an Olympic Sport	Retain. Still relevant.
H-470.980	Hazards of Boxing	Rescind. Covered by H-470.983, "Boxing as a Health Hazard," and H-470.984, "Brain Injury in Boxing".
H-478.990	Tobacco Control Content in Electronic Health Records	Retain. Still relevant.
H-480.972	Medical Device Safety and Physician Responsibility	Retain. Still relevant.
H-495.975	Reducing Tobacco Consumption in the Territory of Guam	Rescind. AMA policy supporting tobacco taxes applies to all jurisdictions.
H-5.997	Violence Against Medical Facilities and Health Care	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
	Practitioners and Their Families	
H-50.979	Use of Blood Therapeutically Drawn from Hemochromatosis Patients	Retain. Still relevant.
H-515.965	Family and Intimate Partner Violence	<p>Retain in part to read as follows:</p> <p>(1) Our AMA believes that all forms of family and intimate partner violence (<u>IPV</u>) 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 <u>survivors</u>. 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.</p> <p>(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 <u>survivors</u>. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.</p> <p>(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 <u>survivors</u> 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</p>

Number	Title	Recommended Action and Rationale
		<p>to:</p> <p>(a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;</p> <p>(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;</p> <p>(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;</p> <p>(d) Have written lists of resources available for victims <u>survivors</u> of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;</p> <p>(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;</p> <p>(f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization <u>IPV</u>;</p> <p>(g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims <u>survivors</u> or abusers themselves;</p> <p>(h) Give due validation to the experience of <u>IPV</u> victimization and of observed symptomatology as possible sequelae;</p> <p>(i) Record a patient's <u>IPV</u> victimization history, observed traumata potentially linked to the IPV <u>victimization</u>, and referrals made;</p> <p>(j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;</p> <p>(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 <u>survivors</u> 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 <u>survivors</u> and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or join state and local health</p>

Number	Title	Recommended Action and Rationale
		<p>departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.</p> <p>(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 <u>survivors</u> of intimate partner violence if the required reports identify victims <u>survivors</u>. 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' <u>survivors'</u> identities;</p> <p>(b) allow competent adult victims <u>survivors</u> to opt out of the reporting system if identifiers are required;</p> <p>(c) provide that reports be made to public health agencies for surveillance purposes only;</p> <p>(d) contain a sunset mechanism; and</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(d) Physicians should be informed about the possible</p>

Number	Title	Recommended Action and Rationale
		pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
H-55.977	Male Breast Cancer	Retain. Still relevant.
H-60.946	Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment	Retain. Still relevant.
H-90.974	Opposition to Obesity as a Disability	Retain. Still relevant.
H-95.955	Physician Impairment	Retain in part to read as follows: (1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of <u>illnesses with the potential to cause impairment</u> problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician <u>illness with the potential to cause impairment</u> , particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.
H-95.962	Inhalant Abuse	Retain. Still relevant.
H-95.975	Substance Use Disorders as a Public Health Hazard	Retain. Still relevant.
H-95.976	Drug Abuse in the United States – the Next Generation	Retain in part with a change in title to read as follows: Drug Abuse in the United States – the Next Generation <u>Addiction and Unhealthy Substance Use</u> Our AMA is committed to efforts that can help <u>the</u>

Number	Title	Recommended Action and Rationale
		<p>this national problem of <u>addiction and unhealthy substance use</u> 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:</p> <p>(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 <u>substance abuse addiction</u>;</p> <p>(2) encourages the development of model substance abuse addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;</p> <p>(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;</p> <p>(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;</p> <p>(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the <u>Substance Abuse and Mental Health Services Administration</u> Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;</p> <p>(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence <u>use disorder</u> as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;</p> <p>(7) affirms the concept that <u>substance abuse addiction</u> 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</p>

Number	Title	Recommended Action and Rationale
		(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-19)

Introduced by: Virginia; American Association of Clinical Urologists; American College of Allergy, Asthma and Immunology; Kansas; South Carolina; Louisiana; Maryland

Subject: USP 800

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, USP <800> becomes effective December 1, 2019 and describes hazardous drug handling related to the receipt, storage, compounding, dispensing, administration, and disposal of both sterile and nonsterile products and preparations in all locations including physician offices; and

Whereas, USP <800> is mainly applicable to large pharmacies and hospitals which employ pharmacists, pharmacy technicians, etc.; and

Whereas, United States Pharmacopeia (USP) standards such as USP <800> are enforced by local, state and federal regulatory agencies such as The Joint Commission, the US Food and Drug Administration, the Centers for Medicare and Medicaid Services, and some state licensing boards; and

Whereas, The National Institute for Occupational Safety and Health (NIOSH) develops risk assessment levels for antineoplastic and other hazardous drugs in healthcare settings; and

Whereas, There is some debate about the NIOSH categorization of some medications previously given safely in the office setting; and

Whereas, USP expressly defined administration as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use in USP Chapter 797 update to be published on June 1, 2019 in the USP-NF, a combination of two compendia, the United States Pharmacopeia (USP) and the National Formulary (NF); and

Whereas, USP defines compounding as the mixing of two or more FDA-approved drugs or ingredients, with exceptions; and

Whereas, National specialty societies can develop white papers/best practices for the safe and appropriate handling of medications utilized in physician offices and systems for ongoing monitoring of potential complications; and

Whereas, If all of the new USP <800> requirements for preparation of medications in the office setting are implemented December 1, 2019, patient access to proven therapies will decrease, costs will increase, and patient harm may result from not receiving needed treatment in a timely manner; therefore be it

1 RESOLVED, That our American Medical Association adopt as policy that physicians and other
2 health care providers administering medications (defined as the mixing or reconstituting of a
3 drug according to manufacturers' recommendations for a single patient for immediate use) not
4 be subject to the USP 800 compounding guidance (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA support development of specialty specific white papers/best
7 practices and systems for both safe medication administration practices and ongoing monitoring
8 of potential complications from the administration of medications deemed suitable for
9 exemptions from the National Institute for Occupational Safety and Health, United States
10 Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of
11 a licensed physician (New HOD Policy); and be it further
12

13 RESOLVED, That our AMA continue its working group, consisting of national specialty
14 organizations, state medical societies and other stakeholders to advocate for such exemptions.
15 (Directive to Take Action)

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

Received: 03/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-19)

Introduced by: Young Physicians Section

Subject: Destigmatizing the Language of Addiction

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Addiction is a chronic brain disease¹ and is the most severe form of substance use disorder, a chronic medical illness with potential for both relapse and recovery²; and

Whereas, Substance use disorder has been recognized by our AMA as a treatable disease³; and

Whereas, 20.1 million Americans have a substance use disorder and only 6.9% receive treatment⁴ and 1 in 7 people in the United States will develop a substance use disorder over the course of their lifetime²; and

Whereas, Substance use disorder has historically been viewed as a moral failing and social problem rather than a chronic medical illness; and

Whereas, Treatment of substance use disorders has been siloed from mainstream healthcare and patients with substance use disorders have been subjected to discrimination and stigma by the healthcare system and healthcare providers; and

Whereas, Language related to substance use disorders shapes attitudes among healthcare professionals towards patients with addiction and commonly used terms like substance abuse and drug abuser explicitly and implicitly convey that patients are at fault for their disease⁵ and influence perceptions and judgments even among highly trained, experienced healthcare professionals⁶; and

Whereas, Negative attitudes among healthcare professionals regarding patients with substance use disorders are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services and poorer patient outcomes⁷; and

Whereas, Existing AMA policy calls for our AMA to take a positive stance as the leader in matters concerning substance use disorders, including addiction⁸ and to assist in reducing the stigma associated with substance use^{3,9}; and

¹ Volkow ND, Koob GF, McLellan AT. Neurobiologic Advances from the Brain Disease Model of Addiction. N Engl J Med 2016; 374:363-371.

² U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

³ AMA Policy, Substance Use and Substance Use Disorders D-95.922

⁴ Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

⁵ Botticelli MP, Koh HK. Changing the Language of Addiction. JAMA 2016;316(13):1361-1362.

⁶ Wakeman SE, Pham-Kanter G, Donelan K. Attitudes, practices, and preparedness to care for patients with substance use disorder: Results from a survey of general internists. Substance Abuse 2016;37(4):635-641.

⁷ van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence 2013;131:23– 35.

⁸ AMA Policy, Substance Use Disorders as a Public Health Hazard H-95.975

⁹ AMA Policy, Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

Whereas, According to the U.S. Surgeon General², clinically accurate, preferred terms include “substance use,” “substance misuse,” “substance use disorder,” “recovery,”³ while non-preferred, stigmatizing terms include “substance abuse,” “drug abuser,” “addict,” “alcoholic,” and “clean” or “dirty”; and

Whereas, AMA PolicyFinder includes a topic heading called “drug abuse” and contains over 70 active policy statements that use non-clinically accurate, stigmatizing terminology, because it has not been recognized by our AMA that such terminology can negatively impact physician attitudes and compromise patient care^{6,7}; therefore be it

RESOLVED, That our American Medical Association use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty (New HOD Policy); and be it further

RESOLVED, That our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities. (Directive to Take Action)

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

Received: 04/04/19

RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922

Our AMA:

- (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
- (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
- (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:

- a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
- b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
- c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;

d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:

a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;

b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and

c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Citation: (Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-19)

Introduced by: Missouri

Subject: Addressing Healthcare Needs of Children of Incarcerated Parents

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, The U.S. is the most heavily incarcerated country in the developed world, and five million, or approximately 7% of American children, have an incarcerated parent^{1,2}; and

Whereas, Parental imprisonment is recognized as one of several known Adverse Childhood Experiences (ACE), with 64% of children with incarcerated parents experiencing two or more additional adverse events including substance abuse, mental illness, and sexual abuse^{1,3}; and

Whereas, Poor health outcomes in children associated with the exposure to parental incarceration include forgone health care, prescription drug abuse, ten or more lifetime sexual partners, higher likelihood of emergency department use, illicit injection drug use, HIV/AIDS, obesity, and behavioral or conduct problems^{1,2,4}; and

Whereas, Although efforts have been made to mitigate the harm associated with having an incarcerated parent, few are focused on meeting the direct health needs of children through preventative health care⁵; and

Whereas, Children with incarcerated parents may benefit from initial ACE screening to identify those who require further assessment, health behavioral counseling, or the establishment of a medical home to help them gain access to care^{2,6}; therefore be it

RESOLVED, That our American Medical Association support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk. (New HOD Policy)

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

Received: 04/16/19

References

- ¹ Lee RD, Fang XM, Luo F. The impact of parental incarceration on the physical and mental health of young adults. *Pediatrics*. 2013; 131(4): 1188-1195. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3608482/>
- ² Heard-Garris N, et al. Health care use and health behaviors among young adults with history of parental incarceration. *Pediatrics*. 2018; 142(2). <http://pediatrics.aappublications.org/content/142/3/e20174314>
- ³ Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258.
- ⁴ Turney, K. Stress proliferation across generations? Examining the relationship between parental Incarceration and childhood health. 2014. <https://journals.sagepub.com/doi/10.1177/0022146514544173#>
- ⁵ Christian S. Children of Incarcerated Parents. National Conference of State Legislatures. 2009. <https://www.ncsl.org/documents/cyf/childrenofincarceratedparents.pdf>
- ⁶ Barnert E, Chung PJ. Responding to parental incarceration as a priority pediatric health issue. *Pediatrics*. 2018; 142(3). <http://pediatrics.aappublications.org/content/142/3/e20181923>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-19)

Introduced by: California

Subject: Screening, Intervention, and Treatment for Adverse Childhood Experiences

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, The Centers for Disease Control and Prevention, the Substance Abuse and Mental
2 Services Health Administration, and the American Academy of Pediatrics have all attributed
3 ACEs (Adverse Childhood Experiences) as a contributing factor for mental health and disease
4 states. ACEs can include physical, mental or sexual abuse or neglect. It also includes children
5 who experience divorce, who have a parent with a substance abuse problem or mental illness,
6 or a relative who is incarcerated; and
7

8 Whereas, ACEs has been associated with myocardial infarction, COPD, mental distress,
9 depression, smoking, disability, substance abuse, coronary artery disease, Alzheimer's disease,
10 stroke and diabetes. ACEs has also been associated with decreased income, unemployment,
11 lack of health insurance, further victimization as adults of abuse and lower education attainment;
12 and
13

14 Whereas, Per the California BRFSS (Behavioral Risk Factor Surveillance System) study, more
15 than 61% of Californians have exposure to at least one ACEs. Identifying and intervening on
16 children early with adequate community, behavioral or mental health resources may benefit
17 children. Adults can be referred for post-trauma treatment or support groups; therefore be it
18

19 RESOLVED, That our American Medical Association support efforts for data collection,
20 research and evaluation of Adverse Childhood Experiences (ACEs), cost-effective ACE
21 screening tools without additional burden for physicians, and effective interventions, treatments
22 and support services necessary for a positive screening practice in pediatric and adult
23 populations (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA support efforts to educate physicians about the facilitators, barriers
26 and best practices for providers implementing ACE screening and trauma-informed care
27 approaches into a clinical setting (New HOD Policy); and be it further
28

29 RESOLVED, That our AMA support additional funding sources for schools, behavioral and
30 mental health services, professional groups, community and government agencies to support
31 children and adults with ACEs. (New HOD Policy)

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

Received: 04/29/19

RELEVANT AMA POLICY**National Child Traumatic Stress Network H-60.929**

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

Citation: (Res. 419, A-11)

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-19)

Introduced by: California
Subject: Glyphosate Studies
Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, Glyphosate is the most commonly produced herbicide and used on multiple
2 agricultural crops, including corn, soy, canola and wheat, and is found in significant amounts in
3 popular household food products; and
4
5 Whereas, The International Agency for Research on Cancer (IARC) under the World Health
6 Organization classified glyphosate as a Group 2A chemical or likely carcinogen in 2015
7 because emerging research indicates it could potentially cause cell damage; and
8
9 Whereas, Research has shown an association between non-Hodkin's lymphoma and
10 glyphosate in human studies and other carcinogenic effects of glyphosate in animal studies; and
11
12 Whereas, Research has also shown that glyphosate can damage DNA in the peripheral blood of
13 exposed humans through oxidative stress; and
14
15 Whereas, Data shows a significant increase in the use of glyphosate on crops in the past 20
16 years especially in the United States; and
17
18 Whereas, The State of California's Office of Environment Health Hazard Assessment (OEHHA)
19 listed glyphosate (the primary chemical in the herbicide branded Roundup) on the list of
20 chemicals known to cause cancer for the purposes of Proposition 65 which now must carry
21 warnings; therefore be it
22
23 RESOLVED, That our American Medical Association advocate for a reduction in the use of
24 glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup),
25 encourage the evaluation of alternatives, and support additional research to determine the long-
26 term effects and association between glyphosate and disease. (Directive to Take Action)

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

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-19)

Introduced by: Illinois

Subject: Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Much misleading information is contained in advertising of herbal remedies and dietary supplements; and

Whereas, Herbal remedies and dietary supplements are sold as food but advertised in such a way as to imply some therapeutic effect of their contents; and

Whereas, Americans spend billions of dollars each year on herbal remedies and dietary supplements in the hope that doing so will enhance their own good health in some way; and

Whereas, Herbal remedies and dietary supplements are not regulated by the US Food and Drug Administration and consequently the identities of their ingredients, active or inactive, and their concentrations are mostly unknown; and

Whereas, Herbal remedies and dietary supplements are not subject to strict regulation, therefore they may or may not have the ingredients listed on the label; and

Whereas, Some herbal remedies and dietary supplements have been documented to have active medications not indicated on the label and some have been documented to contain toxic drugs; and

Whereas, Patients seeking relief of symptoms may turn to herbal remedies and dietary supplements before consulting a medical professional and thus delay the proper diagnosis and therapy for their condition; and

Whereas, Any merchandise that claims to have health benefits is not food; therefore be it

RESOLVED, That our American Medical Association work with the National Center for Complementary and Integrative Health (NCCIH), the federal agency responsible for oversight of herbal remedies and dietary supplements, to institute stricter guidelines for advertising and labeling of these products so that consumers will be informed of what they are purchasing (Directive to Take Action); and be it further

RESOLVED, that our AMA support a licensing body through legislation for manufacturers of dietary supplements and herbal remedies, with the requirement that those manufacturers must supply proof that their products have health benefits (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA urge that the increased cost of a stricter NCCIH program on dietary
- 2 supplements and herbal remedies be paid for by the manufacturers who produce them.
- 3 (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-19)

Introduced by: Illinois

Subject: Removing Ethylene Oxide as a Medical Sterilant from Healthcare

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Ethylene oxide (EtO) is a known human carcinogen as identified by the International Agency for Research on Cancer (IARC) and USEPA. It is used for sterilization of medical equipment that cannot be sterilized by steam. This process is open to the workplace environment at various points allowing the escape of EtO into the area and community. Safer substitution, therefore, should be considered, as alternatives exist that are equally efficacious with respect to sterilization of non-metal products. [6] While many hospitals have switched away from ethylene oxide due to the toxicities, an estimated 80% of non-metallic medical equipment is still being sterilized with EtO at industrial facilities before delivery [6]; and

Whereas, Only 0.05% of the annual production is used for sterilization, sterilization and fumigation is where the highest exposure levels to workers and communities have been measured. [6] Inhaling contaminated air exposes surrounding communities to ethylene oxide when the gas is released from a sterilant facility; and

Whereas, Ethylene oxide exposure is associated with irritation of the respiratory tract, eyes, and skin. [6] With direct contact it can cause burns, blistering, and desquamation of the skin. It can also cause conjunctivitis and contact dermatitis. [6, 4] Acute high-level exposure can cause asthma, and sensitization. [6, 4] It can lead to peripheral neuropathy and central neurotoxicity including neuropsychological abnormalities, and seizures. [4] In animals, exposure has been shown to cause spontaneous abortion, preterm births, and reproductive toxicity in both males and females [4][6]; and

Whereas, In 1984, the International Agency for Research on Cancer (IARC) included ethylene oxide in its list as a probable carcinogen by 2008 with adequate information available only in animals, microorganisms, and invitro. It has been shown to induce sensitive, persistent dose-related frequency of chromosomal aberrations, sister chromatid exchange in peripheral lymphocytes and micronuclei in bone-marrow cells of exposed workers [4][14]; and

Whereas, Epidemiologic studies of humans in 2004, since reviewed by IARC and USEPA, have documented EtO as a Class 1 known human carcinogen. EtO's carcinogenic impact is due to its action as an alkylating agent and specifically has been associated with malignancies of the breast, lymphatic and hematopoietic systems in humans [6][18][19]; and

Whereas, Based on this new information, USEPA changed EtO's adult-based inhalation unit risk from 0.0001 per microgram per cubic meter ($\mu\text{g}/\text{m}^3$) to 0.003 per $\mu\text{g}/\text{m}^3$, a 30-fold increase in cancer potency. In Willowbrook, Illinois, this elevated the additional lifetime risk of 6.4 cancers in a population of 1,000 residents who could be exposed to EtO emissions from a local industrial sterilizing facility. This cancer risk exceeds U.S. EPA's decision-making cancer risk range of 1.0

x 10⁻⁶ to 1.0 x 10⁻⁴, and adds to the lifetime background cancer risk of an average American of 1 in 3 people [24] [25]; and

Whereas, For community exposures no regulations exist save the USEPA's advice with respect to carcinogenic risk and the need for action when the risk exceeds the U.S. EPA's decision-making cancer risk range of 1.0 x 10⁻⁶ to 1.0 x 10⁻⁴; and

Whereas, Due to the impossibility of sterilizing these materials in an enclosed system, safer substitution is the most effective means to address this problem of EtO community exposures. As described by the industry consensus standards Association for the Advancement of Medical Instrumentation, these include radiation sterilization, hydrogen peroxide, nitrogen dioxide and hydrogen peroxide-ozone. The Federal Drug Administration noted in 2016 that hydrogen peroxide was an alternative that they were familiar with and invited applications for sterilization process reviews using this chemical [23]; therefore be it

RESOLVED, That our American Medical Association adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient (New HOD Policy); and be it further

RESOLVED, That our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety. (New HOD Policy)

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

Received: 04/25/19

References:

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-19)

Introduced by: New York

Subject: Benzodiazepine and Opioid Warning

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, During 1999–2017, the rate of drug overdose deaths approximately tripled with
2 approximately 70,000 overdose deaths occurring nationally in 2017, nearly 68 percent involving
3 an opioid; and
4

5 Whereas, By 2017, fentanyl was involved in 57 percent of all drug overdose deaths in New York
6 City; and
7

8 Whereas, Illicitly manufactured fentanyl (a synthetic, short-acting opioid with 50 – 100 times the
9 potency of morphine) has been mixed into heroin, cocaine, and counterfeit pills with or without
10 the users' knowledge, and has increased the risk of fatal overdose; and
11

12 Whereas, Benzodiazepines, often used to aid in relieving symptoms like anxiety, are schedule
13 IV substances available through a physician with a high risk for illicit use; and
14

15 Whereas, Illicit use of benzodiazepines is becoming more common--especially in teens and
16 young adults; and
17

18 Whereas, Benzodiazepines used in excess, can lead to memory loss, dulled emotions,
19 compulsive actions, personality changes and can lead to fatal overdose; and
20

21 Whereas, More than 30 percent of overdoses involving opioids also involve benzodiazepines
22 which include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), and others;
23 and
24

25 Whereas, The dangers of co-prescribing opioids and benzodiazepines has been well known for
26 many years; and
27

28 Whereas, The illegal drug market has been producing illicit alprazolam laced with illicit fentanyl
29 leading to addiction and overdose death; therefore be it
30

31 RESOLVED, That our American Medical Association raise the awareness of its members of the
32 increased use of illicit sedative/opioid combinations leading to addiction and overdose death
33 (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA warn members and patients about this public health problem.
36 (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-19)

Introduced by: International Medical Graduates Section

Subject: Addressing Depression to Prevent Suicide Epidemic

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Major depressive disorder affects approximately 14.8 million American adults in a given year, approximately 6.7 percent of the U.S. population age 18 and older and is the leading cause of disability in the U.S. for ages 15-44; and

Whereas, Roughly 40 million American adults ages 18 and older in a given year, or about 18.1 percent of people in this age group, have an anxiety disorder which is frequently coincident with depressive disorders; and

Whereas, Suicide is the 10th leading cause of death each year in the U.S., claiming the lives of nearly 45,000 people and accounting for \$50.8 billion in cost; and

Whereas, Suicide is the 2nd leading cause of death for people aged 10–34 and more than 90% of people who die by suicide show symptoms of mental illness especially major depressive or bipolar disorder, and substance use disorders; and

Whereas, One doctor per day or 300-400 U.S. physicians die by suicide each year, according to the American Foundation for Suicide Prevention; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH) and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the CDC, the NIH and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression. (Directive to Take Action)

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

Received: 05/01/19

References:

1 U. S. Department of Health and Human Services, <https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html>, "Does depression increase the risk for suicide?"

2 The National Institute of Mental Health, <http://www.nimh.nih.gov>, "Major Depression" and "Suicide."

3 Data on behavioral health in the United States <https://www.apa.org/helpcenter/data-behavioral-health>

4 Mental health by the numbers <https://www.nami.org/learn-more/mental-health-by-the-numbers>

RELEVANT AMA POLICY

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on 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

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

Citation: Res. 910, I-17

Depression and Physician Licensure D-275.974

Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.

Citation: (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12

Senior Suicide H-25.992

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

Citation: (Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-19)

Introduced by: Resident and Fellow Section

Subject: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Cerebrovascular disease is the fifth most common cause of mortality in the United States, responsible for 5.2% of deaths nationwide or 140,000 per year¹; and

Whereas, Intraparenchymal hemorrhages are the most common nontraumatic hemorrhagic stroke and have the highest risk of mortality²; and

Whereas, The largest reversible risk factor for poor outcomes in intraparenchymal hemorrhages is use of anticoagulants, such as warfarin³; and

Whereas, The effects of anticoagulants can be mitigated with rapid use of newer reversal agents, such as prothrombin complex concentrate, which have replaced transfusion as a standard of care⁴; and

Whereas, Many emergency rooms do not know about new anticoagulation reversal medications or do not know how to use them, resulting in worse outcomes for patients prior to transfer to tertiary centers; and

Whereas, Savings in healthcare expenditures and worker productivity are expected with better patient outcomes, while reversal medications are relatively inexpensive; therefore be it

RESOLVED, That our American Medical Association support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications. (New HOD Policy)

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

Received: 05/01/19

References:

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3 Esfahani DR, Radnis CA, Hussein AE, Amin-Hanjani S, Charbel FT, Alaraj A. Thresholds for Volume and Expansion in Intraparenchymal Hemorrhage: Predictors of Neurologic Deterioration and Mortality. World neurosurgery. 2017.

4 Hemphill JC, 3rd, Greenberg SM, Anderson CS, et al. Guidelines for the Management of Spontaneous Intracerebral Hemorrhage: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46(7):2032-2060.

RELEVANT AMA POLICY

Home Anti-Coagulation Monitoring H-185.951

1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.
 2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.
 3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.
- Citation: (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)

Stroke Prevention and Care Legislation H-425.978

Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care.

Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)

The Next Transformative Project: In Support of the BRAIN Initiative H-460.904

Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.

Citation: (Res. 522, A-13; Modified: Res. 514, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-19)

Introduced by: Resident and Fellow Section

Subject: Mandating Critical Congenital Heart Defect Screening in Newborns

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Approximately 18 out of every 10,000 infants are born with a critical congenital heart defect (CCHD)¹; and

Whereas, CCHDs are life-threatening and often require intervention during infancy¹; and

Whereas, Many CCHDs are not detected prenatally or in the immediate post-natal period¹; and

Whereas, The pulse oximetry screening protocol is a low-cost and sensitive screen that can be used to detect CCHD; and

Whereas, A 2013 study in *Pediatrics* estimated screening could potentially identify 1,189 more newborns with CCHD at birth hospitals in the United States annually and screening may cost approximately \$40,000 per life-year saved, which is considered cost-effective²; and

Whereas, Our AMA has policy in support of standardized newborn screening (H-245.973) and newborn hearing screening (H-245.970); and

Whereas, 43 states have taken steps toward newborn screening through legislation, regulations, and hospital guidelines, 35 of which have legislation mandating screening for congenital heart defects³; therefore be it

RESOLVED, That our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge. (New HOD Policy)

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

Received: 05/01/19

¹ American Academy of Pediatrics. (2018) "Newborn Screening for CCHD." Available at <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx>

² Peterson C, Grosse S, Oster M, Olney R, and Cassell C. Cost-effectiveness of routine screening for critical congenital heart disease in US newborns. *Pediatrics* 2013; 132(3).

³ Glidewell J, Olney RS, Hinton C, Pawelski J, Sontag M, Wood T, Kucik J; Daskalov R, Hudson J. State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects — United States, 2011–2014. *CDC Weekly Morbidity and Mortality Report*. 19 June 2015: 64(23):625-630.

RELEVANT AMA POLICY

Standardization of Newborn Screening Programs H-245.973

Our AMA: (1) recognizes the need for uniform minimum **newborn screening** (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09)

Early Hearing Detection and Intervention H-245.970

Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing **screening**, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing **screening** of newborns and infants, prompt evaluation and diagnosis of children referred from **screening** programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss. (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-19)

Introduced by: Resident and Fellow Section

Subject: Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, Cancer treatments in younger patients can lead to reduced fertility¹; and

2
3 Whereas, Studies have demonstrated that oncology patients are interested in the option of
4 fertility preservation²; and

5
6 Whereas, There are several methods to help preserve fertility in pediatric and reproductive aged
7 patients including cryopreserving embryos, oocytes, sperm, or gonadal tissue¹; and

8
9 Whereas, Fertility preservation has not been associated with delayed cancer treatment or
10 decreased survival; and

11
12 Whereas, There are significant geographic and clinic variations in the support for fertility
13 preservation amongst oncologists and fertility specialists; and

14
15 Whereas, There is a lack of adequate provision of information on fertility preservation and lack
16 of referral to fertility clinics for pediatric and reproductive aged oncology patients often resulting
17 from oncologist discomfort in providing adequate counseling to such patients¹; and

18
19 Whereas, There is a significant disparity in access to fertility preservation for pediatric and
20 reproductive aged oncology patients; therefore be it

21
22 RESOLVED, That our American Medical Association encourage disclosure to cancer patients
23 on risks to fertility when gonadotoxicity due to cancer treatment is a possibility (New HOD
24 Policy); and be it further

25
26 RESOLVED, That our AMA support education for providers who counsel patients that may
27 benefit from fertility preservation. (New HOD Policy)

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

Received: 05/01/19

¹ The Ethics Committee of the American Society for Reproductive Medicine. "Fertility Preservation and Reproduction in Cancer Patients." *Ethics Committee Report*, Elsevier, Inc, 11 Mar. 2005, oncofertility.northwestern.edu/sites/oncofertility/files/legacy_files/uploadedfilecontent/ASRM_FP_in_Cancer_2005.pdf

² National Comprehensive Cancer Network. *NCCN Guidelines Version 2.2018 Adolescent and Young Adult Oncology*. 11 Oct. 2017.

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

[Code of Medical Ethics: Opinion 2.1.1 Informed Consent](#)

[Code of Medical Ethics: Opinion 2.1.3 Withholding Information from Patients](#)

[Code of Medical Ethics: Opinion 2.2.1 Pediatric Decision Making](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-19)

Introduced by: Women Physicians Section

Subject: Determining Why Infertility Rates Differ Between Military and Civilian Women

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, According to the Service Women's Action Network (SWAN) December 2018 report,
2 there are more than 369,000 service women (more than 17% of the military) and two million
3 women veterans (10% of veterans population). Further, women comprise 18.5% of all veterans
4 under age 45;¹ and

5
6 Whereas, Infertility rates in military women are significantly higher than the general population;
7 and

8
9 Whereas, A 2018 SWAN survey found that over 37% of active service women reported having
10 difficulty getting pregnant when actively trying after one year (or longer), which is much higher
11 than the reported rate of the general population;² and

12
13 Whereas, The Centers for Disease Control and Prevention reports that approximately 12.1%³ of
14 the general U.S. female population have impaired fecundity, which is a condition related to
15 infertility and refers to women who have difficulty getting pregnant or experience recurrent
16 pregnancy loss;⁴ and

17
18 Whereas, Twenty percent of active service women and 32% of female veterans reported that
19 they did not seek medical services for infertility and cited location, accessibility, and cost as
20 factors;² and

21
22 Whereas, Only six military treatment facilities in the U.S. offer a full range of infertility
23 treatments, and there are often long wait times to access these services;⁵ and

24
25 Whereas, Tricare benefits exclude assisted reproductive technology for veterans, unless it can
26 be demonstrated that a related injury occurred while on active duty;⁶ and

27
28 Whereas, Some women reported being denied care "unless they can demonstrate their infertility
29 is service connected";² and

30
31 Whereas, Without insurance, one round of In Vitro Fertilization treatment can cost \$15,000 or
32 more, with multiple cycles sometimes required for success ;² and

33
34 Whereas, Women in the military are exposed to reproductive health hazards that can increase
35 their risk of infertility;⁷ and

36
37 Whereas, Infertility among service women is often associated with sexual assault and/or
38 combat-related trauma;⁸ and

Whereas, In 2018, the U.S. Department of Defense noted that 79 percent of the reports of sexual assault were from women;⁹ and

Whereas, Survivors of sexual assault are at risk for acquiring sexually transmitted infections such as chlamydia and gonorrhea, which can lead to pelvic inflammatory disease and infertility; and

Whereas, It is unknown whether the etiology of higher infertility rates among service women is related to unique occupational exposures within the military;⁸ therefore be it

RESOLVED, That our American Medical Association advocate for additional research to better understand whether higher rates of infertility in service women may be linked to military service and which approaches might reduce the burden of infertility among service women. (Directive to Take Action)

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

Received: 05/01/19

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1. Department of Defense, Defense Manpower Data Center, unpublished data current as of February 28, 2018.
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3. Centers for Disease Control and Prevention (CDC-P). National Health Statistics Report (2016 July 15). Available at www.cdc.gov/nchs/fastats/infertility.htm.
4. CDC-P. Reproductive Health. Available at www.cdc.gov/reproductivehealth/Infertility.
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9. DoD Releases Annual Report on Sexual Assault in Military. Available at dod.defense.gov/News/Article/Article/1508127/dod-releases-annual-report-on-sexual-assault-in-military/. Accessed March 2019.

RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Citation: CMS Rep. 01, I-16

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Citation: Sub. Res. 224, I-15; Reaffirmation: I-17

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
- (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
- (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
- (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
- (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
- (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
- (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.

Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-19)

Introduced by: American Medical Women's Association

Subject: Opioid Addiction

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, Sex-based differences in response to opioids can result in women developing opioid addiction more readily than men, even when using lower doses for shorter periods of time; and

Whereas, An increasing number of women are addicted to opioids; and

Whereas, Women of child-bearing age who are using opioids inappropriately may be reluctant to seek health care because of the stigma attached to substance use disorder; and

Whereas, Women who used opioids prior to caesarian section are more likely to require opioids for longer periods of time after the procedure; and

Whereas, Enhanced recovery after surgery (ERAS) protocols for caesarian section have been shown to decrease opioid use during hospitalization and after discharge, while improving mobilization and other outcomes; therefore be it

RESOLVED, That our American Medical Association work with constituent organizations to assure that women of child-bearing age who are using opioids and are accessing the health care system undergo evaluation for pregnancy and, if pregnancy, be offered prenatal care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that women who use opioids prior to caesarian section are offered multi-modalities to control pain and improve function after the procedure with the goal of transitioning to other methods of pain control for long term (Directive to Take Action); and be it further

RESOLVED, That our AMA work with hospitals and relevant constituent organizations to assure that the enhanced recovery after surgery protocol for caesarian section is widely adopted to optimize recovery and improve function while decreasing use of opioid medications for pain, especially given the impact of such use in breast-feeding mothers and their infants. (Directive to Take Action)

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

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-19)

Introduced by: American Medical Women's Association

Subject: Reversing Opioid Epidemic

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

1 Whereas, Deaths from overdose of opiates are increasing more rapidly in women than men,
2 with an increase of 5-fold in women compared to 3.6-fold in men between 1999 and 2010; and
3

4 Whereas, These data may be explained by sex-based differences in chronic pain, response to
5 opioids, and risk of opioid addiction; and
6

7 Whereas, Women are more likely to have conditions that lead to chronic pain such as
8 osteoarthritis, inflammatory arthritis, temporal mandibular syndrome, or injuries resulting from
9 intimate partner violence; and
10

11 Whereas, Because of sex-based differences in brain signaling pathways and higher prevalence
12 of untreated co-existing depression and PTSD, women may perceive pain more intensely than
13 men; and
14

15 Whereas, Sex-based differences in response to opioids can result in women developing opioid
16 addiction more rapidly than men, even when using lower doses for shorter time periods, and
17 having greater issues with addiction treatment; therefore be it
18

19 RESOLVED, That our American Medical Association include in their program, Reversing the
20 Opioid Epidemic, education materials for physicians regarding sex-based differences in
21 perception of pain, including the impact of co-morbid conditions, sex-based differences in
22 response to opioids and risks for opioid addiction, and issues with accessing and outcomes of
23 addiction programs among women. (Directive to Take Action)

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

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Alcohol Consumption and Health

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, The Global Burden of Diseases, Injuries, and Risk Factors Study 2016¹ found that, despite a protective effect for ischemic heart disease and diabetes, no level of alcohol consumption minimizes the health loss due all-cause mortality and cancer; and

Whereas, Previous studies suggesting a health benefit for moderate alcohol consumption may have been poorly designed to estimate the full extent of health effects from alcohol due to survival biases, including “sick quitter” hypothesis, and poor study design²; and

Whereas, the Global Burden of Diseases, Injuries and Risk Factors Study 2016 found alcohol to be the 7th leading global risk factor for deaths and disability-adjusted life-years; and

Whereas, Alcohol consumption is a recognized modifiable risk factor for several common types of cancer, including liver, esophageal, oropharyngeal, laryngeal, breast and colon³; and

Whereas, Between 2006 and 2010, the Centers for Disease Control and Prevention reported that 88,000 deaths⁴ were attributed to excessive alcohol consumption in the United States; and

Whereas, Although the greatest risk of cancer is associated with high levels of consumption even light alcohol consumption is associated with a higher risk of esophageal, oral cavity and pharyngeal, and breast cancers with relative risks of 1.26, 1.13, and 1.04 respectively⁵; and

Whereas, The World Cancer Research Fund/American Institute for Cancer Research estimates a 5% increase in premenopausal breast cancer and a 9% increase in postmenopausal breast cancer per 10 grams of ethanol consumed per day⁶; and

Whereas, Consumption of alcohol, without the development of alcoholism or alcohol dependence, is an underappreciated cause of cancer; and

Whereas, Many people engage in excessive drinking without recognition of the risk factors it poses to health, including increased risk of developing cancer; and

¹ GBD 2016 Alcohol Collaborators. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*. 392(10152);22-28: 2018.

² Burton R, Sheron N. No level of alcohol consumption improves health. *Lancet*. 392(10152);22-28: 2018.

³ LoConte, Noelle et al. Alcohol and Cancer: A Statement of the American Society of Clinical Oncology. *J Clin Onc* 2018 36:1, 83-93.

⁴ Centers for Disease Control and Prevention: Alcohol use and health. <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>

⁵ Bagnardi V, Rota M, Botteri E, et al: Alcohol consumption and site-specific cancer risk: A comprehensive dose-response meta-analysis. *Br J Cancer* 112:580-593, 2015.

⁶ World Cancer Research Fund: Diet, nutrition, physical activity and breast cancer. http://www.wcrf.org/sites/default/files/CUP_BREAST_REPORT_2017_WEB.pdf

Whereas, The International Agency for Research on Cancer classified alcohol as a group 1 carcinogen⁷; therefore be it

RESOLVED, That our American Medical Association recognize alcohol consumption as well as alcohol abuse as a modifiable risk factor for cancer (New HOD Policy); and be it further

RESOLVED, That our AMA support research and educational efforts about the connection between alcohol consumption and several types of cancer (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion to read as follows:

"...(4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol consumption, abuse, particularly that which leads to illness, cancer, and accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits..." (Modify Current HOD Policy)

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

Received: 05/01/19

RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16

Alcohol Abuse and the War on Drugs H-30.972

Our AMA (1) supports documenting the strong correlation between alcohol abuse and other substance abuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between alcohol abuse and other substance abuse and recommendations to decrease the immense number of health, safety, and social problems associated with alcohol abuse.

Citation: (Sub. Res. 97, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10

Alcohol Use Disorder and Unhealthy Alcohol Use Among Women H-30.943

The AMA recognizes the prevalence of unhealthy use of alcohol among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol use disorder and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing

⁷ World Cancer Research Fund/American Institute for Cancer Research: Food, Nutrition, Physical Activity, and the Prevention of Cancer: A Global Perspective. Washington, DC, American Institute for Cancer Research, 2007.

fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.

Citation: CSA Rep. 5, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: CSAPH Rep. 01, A-17

Screening and Brief Interventions For Alcohol Problems H-30.942

Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

Citation: CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-19)

Introduced by: American Academy of Dermatology, American Academy of Cosmetic Surgery, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, Missouri, Florida, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society for Aesthetic Plastic Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Wisconsin, South Carolina, American Vein and Lymphatic Society, New York, Utah, International Society of Hair Restoration Surgery

Subject: Compounding

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Our AMA supports appropriate regulatory oversight of compounding pharmacies and facilities engaging in interstate commerce (e.g. compliance with state board of pharmacy and current United States Pharmacopeia and National Formulary compounding standards); and

Whereas, The Drug Quality and Security Act of 2013 increased Food and Drug Administration oversight of compounding pharmacies and has led to burdensome regulatory restrictions on simple preparation of 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

References:

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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:

1. American Red Cross Blood Services. Blood Needs and Blood Supply.
2. Revised Recommendations for Reducing the Risk of Human Immunodeficiency Virus Transmission by Blood and Blood Products - Questions and Answers.
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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.
13. Update: Effects of Lifting Blood Donation Bans on Men who Have Sex with Men. Miyashita, Ayako. Gates, Gary. The Williams Institute. September 2014.
14. What is the evidence for the change in the blood –donation deferral period for high-risk groups and does it go far enough? Beattie RH Sturrock, Stuart Mucklow. *Clin Med (Lond)*. 2018 Aug; 18(4): 304–307.

RELEVANT AMA POLICY

Blood Donor Deferral Criteria H-50.973

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on the scientific literature; and (3) supports research into individual risk assessment criteria for blood donation. Citation: Res. 514, A-13; Modified: Res. 008, I-16

Safety of Blood Donations and Transfusions H-50.975

Our AMA:

- (1) Supports working with blood banking organizations to educate prospective donors about the safety of blood donation and blood transfusion;
- (2) Supports the use of its publications to help physicians inform patients that donating blood does not expose the donor to the risk of HIV/AIDS;
- (3) Encourages physicians to inform high-risk patients of the value of self-deferral from blood and blood product donations; and
- (4) Supports providing educational information to physicians on alternatives to transfusion. Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13

Blood Donor Recruitment D-50.998

1. Our AMA shall encourage the Food and Drug Administration to continue evaluating and monitoring regulations on blood donation and to consider modifications to the current exclusion policies if sufficient scientific evidence supports such changes.
2. Our AMA encourages the U.S. Food and Drug Administration to engage in dialogue with the American Association of Blood Banks and relevant stakeholders to reanalyze their therapeutic phlebotomy policies on variances, including but not limited to hereditary hemochromatosis. Citation: Sub. Res. 401, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 924, I-18

Blood Shortage and Collection H-50.990

In response to a continuing need for blood for transfusion and decreasing supplies of allogeneic blood, our AMA supports programs that encourage donation of blood to the allogeneic supply by health volunteer donors; and the AMA encourages physicians to participate in promotional efforts to encourage blood donation, and urges the American Blood Commission to actively participate in these programs. Citation: Res. 41, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified by CSA Rep. 11, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Voluntary Donations of Blood and Blood Banking H-50.995

Our AMA reaffirms its policy on voluntary blood donations (C-63); and directs attention to the need for adequate donor selection and post-transfusion follow-up procedures. Our AMA (1) endorses the FDA's existing blood policy as the best approach to assure the safety and adequacy of the nation's blood supply; (2) supports current federal regulations and legislation governing the safety of all blood and blood products provided they are based on sound science; (3) encourages the FDA to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States; and (4) urges regulatory agencies and collection agencies to balance the implementation of new safety efforts with the need to maintain adequate quantities of blood to meet transfusion needs in this country. Citation: (BOT Rep. V, A-71; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res. 507, A-98; Appended: CSA Rep. 4, I-98; Reaffirmed: CSA Rep. 1, A-99; Amended & Appended: Res. 519, A-01; Modified: CSAPH Rep. 1, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 523
(A-19)

Introduced by: Michigan

Subject: Availability and Use of Low Starting Opioid Doses

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Our country faces a crisis of opioid dependency, causing 48,000 deaths annually with the number rising year-to-year, also contributing to disability, other health problems, and social breakdown; and

Whereas, Most opioid dependency begins with medically prescribed opioid treatment, with two-six percent of single opioid prescriptions leading to opioid dependency (per Centers for Disease Control and Prevention); and

Whereas, Most initial opioid prescriptions are for hydrocodone 5 mg or oxycodone 5 mg, usually in combination with acetaminophen; and

Whereas, 5 mg hydrocodone and 5 mg oxycodone are fairly strong medications, causing side effects in many, and these are sufficient doses to reinforce abuse in many; and

Whereas, Products consisting of hydrocodone 2.5 mg or oxycodone 2.5 mg in combination with acetaminophen are produced by multiple vendors, but not carried in many pharmacies and, where available, are often sold at substantially higher out-of-pocket price than products with hydrocodone 5 mg or oxycodone 5 mg; therefore be it

RESOLVED, That our American Medical Association reaffirm AMA Policies D-160.981, "Promotion of Better Pain Care," D-120.947, "A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief," D-120.976, "Pain Management," and D-120.971, "Promoting Pain Relief and Preventing Abuse of Controlled Substances," to ensure the dissemination of educational materials for physicians on options for prescribing the lowest effective dosage, such as hydrocodone 2.5 mg or oxycodone 2.5 mg with acetaminophen, for patients who need an initial prescription for an oral narcotic and work with pharmacies and other relevant stakeholders to ensure lower dosage options are stocked and available at prices that do not exceed that of the same narcotic at a higher dosage. (Reaffirm HOD Policy)

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

Received: 05/09/19

RELEVANT AMA POLICY

Promotion of Better Pain Care D-160.981

1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.
 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.
- Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18

A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief D-120.947

1. Our AMA will consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain.
 2. Our AMA will urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents.
 3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities and in the care of patients with cancer and cancer-related pain, in much the same way as is being done for hospice and palliative care.
- Citation: BOT Rep. 3, I-13; Appended: Res. 522, A-16; Modified: Res. 918, I-16; Reaffirmed in lieu of: Res. 803, I-16

Pain Management D-120.976

Our AMA will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that already have already established pain management guidelines; and (4) disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain); and (5) disseminate Council on Science and Public Health Report 5 (A-10), "Maldynia: Pathophysiology and Nonpharmacologic Approaches," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain).

Citation: Res. 809, I-04; Appended: CSAPH Rep. 5, A-06; Appended: CSAPH Rep. 5, A-10; Reaffirmed in lieu of Res. 518, A-12

Promoting Pain Relief and Preventing Abuse of Controlled Substances D-120.971

Our AMA will:

- (1) urge the Drug Enforcement Administration (DEA) to publicly restate their commitment to balance in promoting pain relief and preventing abuse of pain medications;
- (2) support an ongoing constructive dialogue among the DEA and physician groups to assist in establishing a clinical practice environment that is conducive to pain management and the relief of suffering, while minimizing risks to public health and safety from drug abuse or diversion;
- (3) strongly urge that the DEA's upcoming recitation of the pertinent legal principles relating to the dispensing of controlled substances for the treatment of pain maintain a patient-centered focus, including reaffirmation of its previous interpretation of law to permit practitioners to issue a series of prescriptions marked "do not fill" until a later date; and
- (4) strongly urge that the DEA should promulgate, in consultation with relevant medical specialty societies and patient advocacy groups, a rational and realistic set of FAQs to assist in providing education to health care practitioners and law enforcement and regulatory personnel about appropriate pain management, and measures to be taken to minimize drug abuse and diversion.

Citation: BOT Rep. 3, A-06; Reaffirmation A-13; Reaffirmed: BOT Rep. 19, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-19)

Introduced by: Michigan

Subject: Availability of Naloxone Boxes

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, In the United States in 2017, drug related deaths exceeded 72,000 people, of which 49,068 were opioid related leading to 115 opioid overdose deaths per day, the highest in United States history; and

Whereas, Opioid misuse has been associated with excess annual health care expenditures of up to \$20,000 per person on private insurance and up to \$15,000 for those on Medicaid with the Centers for Disease Control and Prevention reporting the total economic burden of prescription opioid misuse in the United States is \$78.5 billion; and

Whereas, Naloxone is an opioid receptor antagonist that reverses the effects of opioid agents, has no potential for abuse, and is harmless to those not experiencing opioid overdose; and

Whereas, Naloxone boxes are a bystander friendly kit designed to accommodate four doses of Naloxone, one rescue breaths mask, and an information card on accessing addiction treatment; and

Whereas, Naloxone boxes are being used throughout Rhode Island and are being considered in Massachusetts to provide easily accessible naloxone in high-risk areas; and

Whereas, A recent feasibility study on public access naloxone kits found that the bystanders in a simulated environment were willing to administer naloxone and 98 percent did so correctly; and

Whereas, The community placement of naloxone boxes is analogous to the widespread distribution of automated external defibrillators (AEDs) in public spaces; and

Whereas, State laws manage how to own, place, and use AEDs, including 1) AED placement mandates requiring certain types of organizations to own AEDs, 2) good Samaritan immunity protecting those who use AEDs in emergent situations against negligence, and 3) general AED law requirements including selecting those who must be trained to use AEDs, administering AED programs managed by the American Heart Association, maintaining AEDs, and reporting AED use; and

Whereas, Although there are no current estimates of the cost of naloxone box kits, generic naloxone costs between \$20 and \$40 and research shows that naloxone distribution for overdose reversal is cost effective; and

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

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RELEVANT AMA POLICY**Child Pornography H-60.990**

Our AMA: (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; and (5) supports efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations.

Citation: BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Appended: Res. 913, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 529
(A-19)

Introduced by: Medical Student Section

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

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, When a federal agency writes a regulation, there is typically a 30-day minimum effective date for rules, 60-day minimum for major rules, and no minimum for good 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

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RELEVANT AMA POLICY

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

Citation: (BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA (1) opposes changes to the New Source Review program of the Clean Air Act; (2) urges the Administration, through the Environmental Protection Agency, to withdraw the proposed New Source

Review regulations promulgated on December 31, 2002; and (3) opposes further legislation to weaken the existing provisions of the Clean Air Act.

Citation: (Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11

Modern Chemicals Policies H-135.942

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

Citation: Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16

Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures H-135.922

Our AMA supports: (1) the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA); and (2) educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients.

Citation: Res. 914, I-17

AMA Advocacy for Environmental Sustainability and Climate H-135.923

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

Citation: Res. 924, I-16

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: (CSAPH Rep. 3, I-08; Reaffirmation A-14

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Res. 402, A-03 Appended: Res. 927, I-11

Assurance and Accountability for EPA's State Level Agencies H-135.924

Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

Citation: Res. 221, A-16

US Efforts to Address Health Problems Related to Agricultural Activities H-365.986

Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities.

Citation: (Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: (Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;

Modified: CSAPH Rep. 1, A-10

Stewardship of the Environment H-135.973

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

(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 530
(A-19)

Introduced by: New Jersey

Subject: Implementing Naloxone Training into the Basic Life Support (BLS)
Certification Program

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

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

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

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

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

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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.
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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