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5.000MSS Abortion

5.001MSS Public Funding of Abortion Services: AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16)


5.005MSS MSS Stance on Challenges to Women’s Right to Reproductive Health Care Access: AMA-MSS opposes legislation that would restrict a woman’s right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician’s ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A-16)

5.006MSS Reproductive Health Care in Religiously-Affiliated Hospitals: AMA-MSS (1) advocates that religiously-affiliated medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution’s willingness to perform the aforementioned services; and (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient. (MSS Res 13, A-17)

5.007MSS Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone: AMA-MSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (MSS Res 14-I-17)

10.000MSS Accident Prevention


**10.003MSS**  
**Mandatory Labeling for Waterbeds and Beanbag Furniture:** AMA-MSS will ask the AMA to encourage waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and distribute warning materials on each waterbed and other furnishings concerning the risks of leaving an infant or handicapped child who lacks the ability to roll over unattended on a waterbed or beanbag furniture. (AMA Amended Res 414, A-92 Adopted [H-245.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**10.006MSS**  
**In-Line Skating Injuries:** AMA-MSS will ask the AMA to: (1) strongly recommend that all in-line skaters wear protective helmets, wrist guards, and elbow and knee pads, and support efforts to educate adults and children about in-line skating safety; and (2) encourage the availability of all safety equipment at the point of in-line skate purchase or rental. (AMA Sub Res 403, A-95, Adopted [H-10.975]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-10.975 Rescinded: CCB/CLRPD Rep. 1, A-14) (Reaffirmed: MSS GC Rep D, I-15)

**10.008MSS**  
**Promoting the Universal Use of Bicycle Helmets:** AMA-MSS encourages chapters to take advantage of current funding sources for community service initiatives to promote bicycle helmet use and to conduct events in their communities on safety education for all ages. (MSS Amended Res 12, A-09) (Reaffirmed: MSS GC Rep A, I-14)

**10.009MSS**  
**Use of Protective Eyewear by Young Athletes:** AMA-MSS will ask the AMA to establish policy in support of the use of protective eyewear for athletes who have had eye surgery or trauma, or are functionally one-eyed individuals, and for all other athletes engaged in high eye-risk sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology. (MSS Sub Res 15, A-98) (AMA Amended Res 404, I-98, Adopted [H-10.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

**10.010MSS**  
**Return to Play After Suspected Concussion:** AMA-MSS will ask the AMA to support the prohibition of athletes under age 18, who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, from returning to play or practice without a licensed health care provider's written approval. (MSS Res 24, A-10) (AMA Amended Res 910, I-10 Adopted [H-470.959]) (Reaffirmed, MSS GC Rep D, I-15)

**10.011MSS**  
**Skiing and Snowboarding Helmets and Safety:** AMA-MSS will ask the AMA to (1) actively support skiing and snowboarding helmet use and encourage physicians to educate their patients about the importance of skiing and snowboarding helmet use; (2) encourage the manufacture, distribution, and utilization of safe, effective, and reasonably priced skiing and snowboarding helmets; (3) encourage the availability of helmets at the point of skiing and snowboarding purchase; and (4) develop model state/local legislation requiring the use of skiing and snowboarding safety helmets in the pediatric population, and calling for all who rent skis and snowboards to the pediatric population to offer the rental of skiing and snowboarding safety helmets. (MSS Res 25, A-10) (AMA Substitute Res 911, I-10 Adopted [H-470.974]) (Reaffirmed, MSS GC Rep D, I-15)

**10.012MSS**  
**Helmet Safety:** AMA-MSS will ask the AMA to amend H-470.974 by insertion and deletion as follows:

H-470.974 Athletic Helmets
Our AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horseback riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to 14 18 years of age; that the AMA encourage the use of protective helmets and face shields to be worn by all baseball and softball pitchers in organized leagues from 5 to 18 years of age. 2. Our AMA: (a) supports legislation requiring the use of helmets by children ages 17 and younger while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing, and snowboarding; (b) encourages the use of helmets in adults while engaged in potentially dangerous athletic activities, including but not limited to sledding, snow skiing and snowboarding; (c) encourages physicians to educate their patients about the importance of helmet use while engaged in potentially dangerous athletic activities, including but not limited to sledding, skiing and snowboarding; and (d) encourages the availability of rental helmets at all commercial sledding, skiing and snowboarding areas.


10.013MSS Implementing Bike Lanes to Improve Overall Bicyclist Safety: AMA-MSS supports research on the safety and efficacy of the implementation of various forms of bicycle lanes in reducing crash incidence and severity. (MSS Res 39, I-13)

10.014MSS Improving the Safety of Playgrounds through Height Restrictions: AMA-MSS supports the adoption of height restrictions and minimum protective surfacing requirements for playground equipment. (MSS Res 11, A-14)

15.000MSS Accident Prevention: Motor Vehicles

15.001MSS State Motorcycle Helmet Laws: Our AMA-MSS will ask the AMA to: (1) endorse the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (2) urge constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (3) join, when requested, with constituent societies to support the enactment or preservation of state motorcycle helmet laws. (AMA Res 77, I-80, Adopted [H-15.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-15.994 Rescinded: CCB/CLRPD Rep. 3, A-14) (Reaffirmed: MSS GC Rep D, I-15)


15.009MSS Seatbelt Use in Young Drivers and Passengers: AMA-MSS will ask the AMA to urge physicians to take an active stance with their young patients on the importance of safety in motor vehicles through routine questioning regarding passenger seat belt use during every history and physical exam. (MSS Sub Res 10, A-01) (Reaffirmed existing policy in lieu of AMA Res 402, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

15.010MSS Seat Belt Compliance in Emergency Vehicle Patient Compartments: AMA-MSS will ask the AMA to collaborate with national emergency medicine and emergency medical services organizations to develop educational resources and training for employees regarding seat belt usage in the patient compartments of emergency vehicles; and (2) support the amendment of state seat belt laws with blanket exemptions for emergency medical services personnel such that these laws provide exemptions only when actively involved in patient care. (MSS Res 22, A-10) (AMA Amended Res 909, I-10, Adopted [H-15.982]) (Reaffirmed, MSS GC Rep D, I-15)

15.011MSS Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs: AMA-MSS supports more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. (MSS Res 32, A-18)

20.000MSS Acquired Immunodeficiency Syndrome (AIDS)


20.002MSS AIDS Education: AMA-MSS: (1) encourages public school instruction, appropriate for a student's age and grade, on the nature of HIV and the prevention of its transmission starting at the earliest age at which health and hygiene are taught; (2) asks the AMA to encourage the training of appropriate school personnel to assure a basic knowledge of the nature of HIV, the prevention of its transmission, the availability of appropriate resources for counseling and referral, and other information that may be appropriate considering the ages and grade levels of pupils. (MSS Sub Res 4, A-87) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed MSS GC Report A, I-17)

20.005MSS Drug Availability: AMA-MSS will ask the AMA, as set forth in its objective of contributing to the betterment of the public health, to: (1) use its resources in cooperation with other health care organizations and agencies to facilitate the distribution of information on drug therapy availability for AIDS; and (2) encourage the FDA to continue to expedite the evaluation of available drugs used in the treatment of AIDS (AMA Res 177, A-88 Adopted as Amended [H-20.922]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

20.006MSS AIDS Prevention Through Educational Programs: AMA-MSS will ask the AMA to support attention to language and cultural appropriateness in HIV educational materials and encourage the


20.010MSS Comprehensive HIV Programs in Correctional Facilities: AMA-MSS will ask the AMA to encourage correctional systems at the federal and state levels to provide comprehensive medical management to all prisoners, including treatment, counseling, education, and preventive measures related to HIV infection. (AMA Res 180, I-90 Referred) (BOT Rep RR, I-90 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: GC Rep F, I-10) (Reaffirmed: GC Rep D, I-15)

20.011MSS Non-Consensual HIV Testing: AMA-MSS will ask the AMA to support allowing HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with the HIV virus in federally operated health care facilities (AMA Amended Res 415, I-91 Adopted [H-20.899]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: GC Rep F, I-10) (Reaffirmed: GC Rep D, I-15)

20.012MSS Policy Regarding HIV Infected Medical Students: AMA-MSS will ask the AMA to take the stand that a medical student who becomes infected with human immunodeficiency virus (HIV) and other blood-borne infectious diseases should not be prevented from completing his or her course of study and receiving their MD/DO degree based solely on their HIV seropositivity. (AMA Amended Res 413, I-92 Adopted [H-295.937]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (H-295.937 Rescinded, CME Rep. 2, A-13) (Reaffirmed: GC Report A, I-16)


20.014MSS Promotion of Rapid HIV Test: AMA-MSS will ask the AMA to work with any and all local and state medical societies, and other interested U.S. and international organizations to increase access to and utilization of FDA approved rapid HIV testing by personnel appropriately trained in test administration and results counseling. (MSS Res 30, I-04) (AMA Amended Res 511, A-05 Adopted [D-20.993]) (Reaffirmed: GC Rep D, I-11) (Reaffirmed: GC Report A, I-16)


20.017MSS HIV Positive Immigration and Permanent Residency in the U.S.: AMA-MSS will ask the AMA to amend H-20.901 by insertion and deletion as follows:

H-20.901 HIV, Immigration, and Travel Restrictions

Our AMA: (1) Supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649); (2) Recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) Supports keeping HIV infection on the list of communicable diseases of "Public Health Significance" for purposes of immigration law and supports excluding immigrants infected with HIV from settling permanently in the United States; (4) Recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (5) Recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.


20.018MSS Averting Antiretroviral Treatment Rationing in the United States – Strengthening the AIDS Drug Assistance Program: AMA-MSS will ask the AMA to lobby the United States Congress to expand funding to ensure coverage for all current and future qualified individuals for the AIDS Drug Assistance Program. (MSS Res 34, A-11) (Reaffirmed Existing Policy in Lieu of AMA Res 210, I-11) (Reaffirmed: MSS GC Report A, I-16)

20.019MSS Modernization of HIV Specific Criminal Laws: AMA-MSS will ask the AMA to amend policy H-20.914 via insertion and deletion as follows:

H-20.914 Discrimination and Criminalization Based on HIV Seropositivity

Our AMA:
Remains cognizant of and concerned about society's perception of, and discrimination against, HIV-positive people; (2) Condemns any act, and opposes any legislation of categorical discrimination based on an individual's actual or imagined disease, including HIV infection; this includes Congressional mandates calling for the discharge of otherwise qualified individuals from the armed services solely because of their HIV seropositivity; (3) Encourages vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate against persons based on disease; and (4) Encourages medical staff to work closely with hospital administration and governing bodies to establish appropriate policies regarding HIV-positive patients; and (5) Supports consistency of federal and state criminal laws with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention, including avoidance of any imposition of unwarranted punishment based on health and disability status; and (6) Encourages public education and understanding of the stigma created by HIV criminalization statutes and subsequent negative clinical and public health consequences.


20.021MSS Support Offerings HIV Post Exposure Prophylaxis to All Survivors of Sexual Assault: AMA-MSS will ask the AMA to (1) advocate for education of physicians about the effective use of Post-Exposure Prophylaxis for HIV and the US PEP Clinical Practice Guidelines; (2) support increased public education about the effective use of Post-Exposure Prophylaxis for HIV; and (3) amend policy H-20.900 by insertion as follows:
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HIV, Sexual Assault, and Violence H-20.900
Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.
(MSS Res 19, A-18)

20.022MSS Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals: AMA-MSS will ask the AMA to support repealing legislation criminalizing non-disclosure of Human Immunodeficiency Virus (HIV) status of people living with HIV who have an undetectable viral load. (MSS Res 41, I-18) (AMA Res 432, A-19, Appended [H-20.914])

25.000MSS Aging
25.001MSS Geriatric Delirium Screening: AMA-MSS will ask the AMA to support efforts to educate physicians regarding the importance of delirium screening for clinically relevant patients 65 years of age or older, using an evidence-based and validated delirium detection tool. (MSS Res 17, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

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

25.003MSS Increased Affordability and Access to Hearing Aids and Related Care: AMA-MSS will ask the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2) encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (MSS CEQM Rep I-18, Adopted) (AMA Res 124, A-19, Adopted [H-18.929])

30.000MSS Alcohol and Alcoholism
30.001MSS Medical Student and House-staff Alcoholism: AMA-MSS will ask the AMA to (1) encourage medical schools to provide peer counseling groups for addicted students; (2) aid and support medical schools in the identification of alcohol and drug treatment programs; (3) urge medical schools to grant leaves of absence to addicted students to seek treatment; and (4) support the formation of a national or regional committee of addiction and rehabilitation experts who may evaluate and recommend desirability of readmission for expelled students. (AMA Amended Res 83, I-82 Adopted [H-30.961]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

30.003MSS Age Requirement for Purchase of Non-Alcoholic Beer: AMA-MSS will ask the AMA to: (1) support accurate and appropriate labeling disclosing the alcohol content of all beverages including so-called "non-alcoholic" beer and of other substances as well, including over-the-counter and...
prescription medications with removal of "non-alcoholic" from the label of any substance containing any alcohol; (2) support efforts to educate the public and consumers relating to the alcohol content of so-called "non-alcoholic" beverages and other substances, including medications, especially as related to consumption by minors; and (3) express strong disapproval of any consumption of beer by persons under 21 years of age which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol. (AMA Amended Sub Res 217, I-91 Adopted [H-30.940]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

30.005MSS Boating Under the Influence: AMA-MSS will ask the AMA to (1) support legislation for adequate education on the dangers of alcohol and drug consumption for the safe operation of recreational water craft; and (2) support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs. (AMA Res 405, I-93 Adopted [H-30.951]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

30.006MSS Support of Programs that Discourage Adolescent Alcohol Consumption: AMA-MSS strongly encourages AMA-MSS chapters to work with adolescents in their local communities in order to both raise awareness of the dangers of alcohol consumption by minors as well as to curtail underage drinking in their local populations. (MSS Res 28, I-03) (Reaffirmed: MSS Rep E, I-08) Modified: MSS GC Rep B, I-09) (Reaffirmed: GC Rep B, I-13)


30.008MSS Support for Medical Amnesty Policies for Underage Alcohol Intoxication: AMA-MSS will ask the AMA to support efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment when seeking emergency medical attention for themselves or others. (Sub MSS Res 32, I-11) (AMA Res 202, A-12 Adopted as Amended [H-30.938]) (Reaffirmed: MSS GC Report A, I-16)

30.009MSS Sobriety Checkpoints: That our AMA (1) support the use of sobriety checkpoints to deter driving following alcohol consumption; and (2) work with state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints. (MSS Res 22, A-14) (AMA Res 202, I-14 Adopted as Amended [H-15.990])

50.000MSS Blood

50.002MSS Use of Blood Therapeutically Drawn from Hemochromatosis Patients: AMA-MSS will ask the AMA to advocate the acceptance of blood drawn therapeutically from patients with hemochromatosis as a measure to correct the shortage in the blood supply, provided that methods are in place to ensure the donor’s altruistic intent to use the blood for transfusion. (MSS Sub Res 1, I-97) (AMA Res 504, A-98 Referred) (CSA Rep 1, A-98 Adopted) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS Report A, I-17)

50.003MSS Blood Donation by HIV Negative Homosexual Males: AMA-MSS will ask the AMA to encourage the Food and Drug Administration to continue evaluation and monitoring of regulations on blood
donation by men who have had sex with other men, and to consider making modifications to the
current deferral policies if sufficient scientific evidence becomes available to support such a
change. (MSS Rep A, I-01) (AMA Sub Res 401, A-02 Adopted [H-50.977]) (Reaffirmed: MSS

**50.004MSS**

**Blood Donor Deferral Criteria Revisions:** AMA-MSS will ask that our AMA (1) amend policy H-
50.973 by addition and deletion to read as follows:

Blood Donor Deferral Criteria H-50.973

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 level of individual risk;
and (2) opposes the current lifetime a deferral on blood and tissue donations from men who have
sex with men not based in science; and (3) supports research into Individual Risk Assessment
criteria for blood donation. ; and

(2) advocate for the elimination of current deferral policy and ask the Food and Drug
Administration to develop recommendations for Individual Risk Assessment during the public
commentary period. (MSS Res 25, I-16 Immediate Transmittal)

**55.000MSS**

**Cancer**

**55.001MSS**

**Testicular Cancer Self Examination:** AMA-MSS will ask the AMA to promote national awareness
of the problem of testicular cancer and to support programs of education in the proper method
of self-examination to lead to early detection of testicular cancer. (AMA Res 28, I-87 Adopted [H-

**55.002MSS**

**Mass Screening for Neuroblastoma:** AMA-MSS will ask the AMA to encourage the
implementation of mass screening programs for neuroblastoma in each state and work to increase
public awareness of the benefits of a mass screening program for neuroblastoma. (AMA Res 76,
A-90 Referred) (BOT Rep Q, I-90 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS

**55.003MSS**

**Screening and Education Programs for Breast and Cervical Cancer Risk Reduction:** AMA-MSS
will ask the AMA to (1) support programs to screen all women for breast and cervical cancer; (2)
support government funded programs available for low income women; and (3) support the
development of public information and educational programs with the goal of informing all women
about routine cancer screening in order to reduce their risk of dying from cancer. (AMA Amended
(Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (H-55.985 Rescinded:
CCB/CLRDP Rep. 3, A-14)

**55.004MSS**

**Use of the Anal Pap Smear as a Screening Tool for Anal Dysplasia:** AMA-MSS will ask the AMA
to support continued research on the diagnosis and treatment of anal cancer and its precursor
lesions and to promote awareness of the current research regarding the utility of anal pap smears as
a screening tool for anal cancer. (MSS Rep C, I-03) (AMA Amended Res 512, A-04 Adopted [H-
460.913]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

**55.006MSS**

**9/11 Early Responder Health Coverage of Cancer:** AMA-MSS will ask the AMA to encourage
further study of the association between post-September 11, 2001 World Trade Center attack
(Reaffirmed: MSS GC Report A, I-16)

55.007MSS Adolescent and Young Adult Cancer: (1) AMA-MSS encourages further research into the scientific basis, treatment, and diagnosis of Adolescent and Young Adult Cancers; and (2) AMA-MSS promotes education and research about the unique challenges to treating adolescents and young adults with cancer, and promote solutions to these challenges. (MSS GC Rep D, A-12)
(Reaffirmed: MSS GC Report A, I-17)

60.000MSS Children and Youth

60.001MSS Medical Family History in Adoptions: AMA-MSS stands in favor of a change in adoption procedures that would require adoption agencies to obtain a complete family medical history and permit the adoptee to have access to this information while still maintaining confidentiality. (MSS Res 1, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

60.002MSS Provision of Health Care and Parenting Classes to Adolescent Parents: AMA-MSS will ask the AMA to (1) encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings that provide health care for infant and mother and child development classes in addition to current high school courses and (2) support programs directed toward increasing high school graduation rates, improving parenting skills, and decreasing future social service dependence of teenage parents. (AMA Amended Res 422, I-91 Adopted [H-60.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

60.006MSS First Aid Training For Child Daycare Workers: AMA-MSS will ask the AMA to recommend that all licensed child daycare facilities have a minimum of one employee currently certified in first aid including adult/pediatric and infant CPR and foreign body airway management, on site and available during all business hours. (AMA Amended Res 213, I-94 Adopted [H-60.957]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-60.957 Rescinded: CSAPH Rep. 1, A-14) (Reaffirmed: MSS GC Rep D, I-15)


60.010MSS Encouraging Vision Screenings for Schoolchildren: AMA-MSS will ask the AMA to: (1) encourage and support outreach efforts to provide vision screenings for school-age children prior to primary school enrollment and (2) encourage the development of programs to improve school readiness by detecting undiagnosed vision problems and support periodic pediatric eye screenings with referral for comprehensive professional evaluation as appropriate. (MSS Res 15, A-04) (AMA Amended Res 430, A-05 Adopted [H-425.977]) (Reaffirmed: MSS Res 53, A-15)

60.011MSS Sun Protection Programs in Elementary Schools: AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (MSS Res 16, A-04) (Reaffirmed: MSS Res 16, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
60.012MSS  Teen and Young Adult Suicide in the United States: AMA-MSS will ask the AMA to recognize teen and young-adult suicide as a serious health concern in the United States and compile resources to reduce teen and young adult suicide, including but not limited to CME classes, patient education programs and other appropriate educational and interventional programs for health care providers, and Rep Back at A-05. (MSS Res 18, A-04) (AMA Amended Res 424, A-05 Adopted [H-60.937]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

60.014MSS  Establishment of a National Immunization Registry of “Vaccines for Children” Enrolled Patients: AMA-MSS will ask the AMA to (1) work with the Centers for Disease Control, the Department of Health and Human Services, the United States Public Health Service Health, and other interested organizations to develop a National Immunization Registry (NIR) that considers the use of information technology to manage and access information contained within it and (2) ensure that any National Immunization Registry (NIR) that is created protects the patient-physician relationship. (MSS Rep B, A-05) (AMA Sub Res 709, I-05 Adopted [D-440.961]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


60.016MSS  Ensuring Best Care for Children with Diabetes in School: AMA-MSS will ask the AMA to support the implementation of rigorous training programs under physician oversight, including frequent refresher courses, for selected school staff members to dose and administer injectable medications in emergency situations and to aid the child in their self-administration of insulin in the case that a licensed medical professional is not available. (MSS GC Rep B, A-06) (CSAPH Rep. 4, A-08, Adopted [H-60.932]) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

60.017MSS  Disclosure of Health Status to Children and Adolescents: AMA-MSS will ask the AMA to encourage relevant members of the Federation of Medicine, as well as relevant non-physician organizations, to provide ongoing communication, support, and training to health care providers to assist parents with disclosing their children’s health status, in particular their HIV status, to them in a timely and prudent manner. (MSS Amended Res 5, A-09) (AMA Res 2, I-09 [D-60.970]) (Reaffirmed: MSS GC Rep A, I-14)

60.018MSS  Body Image and Advertising to Youth: AMA-MSS will ask the AMA to encourage advertising associations to work with public and private sector organizations concerned with adolescent health to develop guidelines for advertisements, especially those appearing in teen-oriented publications, that would discourage the altering of photographs in a manner that could promote unrealistic expectations of appropriate body image. (MSS Res 26, A-10) (AMA Res 414, A-11 Adopted as Amended [H-60.928]) (Reaffirmed, MSS GC Rep D, I-15)

60.019MSS  Reducing the Incidence of Back Pain in Schoolchildren by Encouraging the Proper Use of Backpacks: AMA-MSS supports guidelines to encourage proper use of backpacks by schoolchildren by recommending lighter loads and the use of both shoulders. (MSS Res 33, I-10) (Reaffirmed: MSS GC Rep D, I-15)

60.020MSS  Reduction of Online Bullying: AMA-MSS will ask the AMA to urge social networking platforms to adopt Terms of Service that define and prohibit cyber-bullying and cyber-hate. (MSS Res 23, A-11) (AMA Res 401, A-12 Adopted as Amended [H-515.959]) (Reaffirmed: MSS GC Report A, I-16)
60.021MSS Implementation and Funding of Childcare Services for Patients: AMA-MSS will ask the AMA to encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients. (MSS Res 21, A-12) (AMA Res 701, A-13 Not Adopted) (Reaffirmed: MSS GC Report A, I-17)

60.022MSS Altering School Days to Alleviate Adolescent Sleep Deprivation: That our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that the AMA support legislation congruent with those guidelines. (MSS Res 31, A-14) (AMA Res 404, A-15 Referred)

60.023MSS Legal Protection and Social Services for Commercially Sexually Exploited Youth: That our AMA work with state medical societies to (1) advocate for legal protection for commercially sexually exploited youth as an alternative to prosecution for crimes related to sexual exploitation, and (2) encourage the development of appropriate, comprehensive, trauma-informed services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (MSS Res 40, A-14) (MSS Res 4, I-14 Adopted as Amended [D-60.969])

60.024MSS Reporting Child Abuse in Military Families: AMA-MSS will ask the AMA to support all state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense. (MSS Res 22, I-17)

60.025MSS Addressing the Need for Standard Evidence-Based Screening Tools to Improve Care of Adolescent and Pediatric Patients with Depression: AMA-MSS will recognize the lack of validated screening tools for pediatric mental illness and promote the research into the validation, development, and implementation of evidence-based routine mental health screenings. (MSS Res 47, A-18)

60.026MSS Support for Children of Incarcerated Parents: AMA-MSS will ask the AMA to support legislation and initiatives that provide resources and support for children of incarcerated parents. (MSS Res 03, I-18) (AMA Res 503, combined with Res 531, A-19, Adopted as amended, [H-60.903])

60.027MSS National Guidelines for Guardianship: AMA-MSS will ask the AMA to collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures. (MSS Res 55 I-18) (AMA Res 19, A-19, Referred)

60.028MSS Ensuring the Best In-School Care for Children with Sickle Cell Disease: AMA-MSS will ask the AMA to (1) support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises, and (2) support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (MSS Res 30, A-19)

60.029MSS Affirming the Right of Minors to Consent to Vaccinations: AMA-MSS supports legislation that allows mature minors to provide consent for routine immunizations as recommended by the Centers for Disease Control and Prevention. (MSS Res 48, A-19)

60.030MSS Support for Requiring Investigations into Deaths of Children in Foster Care: AMA-MSS will ask the AMA to support legislation requiring investigations into deaths of children in the foster care system while the child is in the foster care system. (MSS Res 65, I-18) (AMA Res 018, A-19, Adopted [H-60.904])
65.000MSS  Civil and Human Rights

65.002MSS  Nondiscrimination Based on Sexual Orientation: AMA-MSS continues to support its positions that nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice. (AMA Res 12, A-89 Adopted [H-295.969]) (Reaffirmed: MSS Rep D, I-99) (Modified: MSS GC Rep A, I-16)

65.005MSS Disseminating Information to Combat Ethnic Retaliation and Racism: AMA-MSS will work to raise awareness about incidents of ethnic retaliation and racism with the goal of reducing the occurrence of such incidents in the future. (MSS Sub Res 7, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

65.007MSS Gender-Specific Rehabilitative Programs, Mental Health, and Educational Services for Girls in the Juvenile Detention System: AMA-MSS will ask the AMA to work with appropriate organizations to evaluate gender-specific rehabilitation programs, mental health services, and educational services in juvenile detention centers. (MSS Sub Res 10, I-02) (AMA Amended Res 411, A-03 Adopted [H-170.967]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

65.008MSS Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population: AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or perceived gender" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender." (MSS Res 27, A-03) (AMA Res 414, A-04 Adopted [D-65.996]) (Amended: MSS Res E, I-08) (Reaffirmed: GC Rep B, I-13)

65.009MSS Same-Sex and/or Opposite Sex Non-Married Partner: AMA-MSS will ask the AMA to support legislative and other efforts to allow the adoption by the same-sex and/or opposite sex non-married partner who functions as a second parent or co-parent of children who are born to or adopted by one member. (MSS Res 24, I-03) (AMA Res 204, A-04 Adopted [H-60.940]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

65.010MSS Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender Health Issues on Medical School Campuses: AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourages the LCME to require all medical schools to incorporate GLBT health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

65.011MSS Physician Objection to Treatment and Individual Patient Discrimination: AMA-MSS will ask the AMA to: (1) reaffirm that physicians can conscientiously object to the treatment of a patient only in non-emergent situations; and (2) support policy that when a physician conscientiously objects to serve a patient, the physician must provide alternative(s) which include a prompt and appropriate referral. (MSS Res 14, I-05) (AMA Res 005, A-06 Referred) (CEJA Rep 6, A-07 Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
65.012MSS  Removing Barriers to Care for Transgender Patients: AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician. (MSS Amended Res 11, I-07) (AMA Res 122, A-08 Adopted as Amended in Lieu of AMA Res 114 and 115 [H-185.950]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

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

65.014MSS  Marriage Equality and Repeal of the Defense of Marriage Act: (1) AMA-MSS will ask the AMA to support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian individuals and couples, their families, and their children; (2) AMA-MSS supports the repeal of the “Defense of Marriage Act,” as it discriminates against married same-sex couples and their families and directly contributes to health care disparities among the gay, lesbian, bisexual, and transgender (GLBT) community. (MSS Res 30, A-10) (AMA Res 209, I-10 Referred) (Reaffirmed: MSS GC Rep D, I-15)

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

65.016MSS  Elimination of Health Care Disparities Resulting from Insurance Status: AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations. (MSS Sub Res 29, A-11) (Reaffirmed: MSS GC Report A, I-16)


65.018MSS  Preventing Discrimination against Patients by Medical Students: AMA-MSS will ask the AMA to oppose the refusal by medical students to treat patients on the basis of the patient’s race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (AMA Res 4, I-12) (Amended AMA Res 1, A-13 Adopted [H-295.865]) (Reaffirmed: MSS GC Report A, I-16)

65.019MSS  Conforming Birth Certificate Policies to Evolving Medical Standards for Transgender Patients: AMA-MSS supports (1) policies that reduce barriers to and allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a health care provider that the individual is undergoing or has undergone gender transition according to applicable medical standards of care; and (2) that sex designation on an individual’s birth certificate, or any change thereof, not hinder access to appropriate medical care. (MSS Res 12, I-13)
Policies on Intimacy and Sexual Behavior in Residential Aged Care Facilities: AMA-MSS will ask (1) that our AMA urge long-term care facilities and other appropriate organizations to adopt policies and procedures on intimacy and sexual behavior that preserve residents' rights to pursue sexual relationships, while protecting them from unsafe, unwanted, or abusive situations, and (2) that our AMA urge long-term care facilities and other appropriate organizations to provide staff with in-service training to develop a framework to address intimacy in their patient population. (MSS Res 14, I-15) (AMA Res 403, A-16 Adopted)

Addressing Patient Spirituality in Medicine: AMA-MSS will ask (1) That our AMA support inquiry into, as well as discussion and consideration of, individual patient spirituality as an important component of health; and (2) That our AMA encourage expanded patient access to spiritual care services and resources beyond trained healthcare professionals. (MSS Res 14, A-16)

Protection of Transgender Individuals’ Right to Use Public Facilities in Accordance with Their Gender Identity: AMA-MSS supports transgender individuals’ right to use public facilities in accordance with their gender identity to mitigate harms. (MSS Res 01, A-17)

Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: AMA-MSS will ask that our AMA (1) publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+ population; (2) promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; (3) amend AMA policy H-65.976 by addition and deletion to read as follows:

Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

(4) amend AMA policy H-160.991 by addition and deletion to read as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual, and transgender, queer/questioning, and other (LGBTQ+) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ+. (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ+ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+ patients; (iii) encouraging the development of educational programs in LGBTQ+ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients; and (c)
opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ+ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ+ people.

(MSS Res 10, A-17)

65.024MSS FMLA-Equivalent for LGBT Workers: AMA-MSS will ask the AMA to support the expansion of policies regarding family and medical leave to include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship. (MSS Res 03, I-17)

65.025MSS Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training: AMA-MSS will ask the AMA to work with appropriate stakeholders to support the creation of a model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations. (MSS Res 09, A-19)

65.026MSS Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems: AMA-MSS will ask the AMA to amend policy H-315.967, Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation by insertion as follows:

Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), preferred name, and an inventory of current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient
regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (MSS Res 36, A-19)

65.027MSS Removing Sex Designation from the Public Portion of the Birth Certificate: AMA-MSS will ask the AMA to advocate for removal of “sex” as a designation on the public portion of the birth certificate and that it be visible for medical and statistical use only. (MSS Res 43, A-19)

65.028MSS Encourage Federal Efforts to Expand access to Scheduled Dialysis for Undocumented Persons: AMA-MSS will ask the AMA to support expanded access to scheduled dialysis for undocumented persons with end-stage renal disease. (MSS Res 51, A-19)

65.029MSS Opposing Mandated Reporting of People who Question their Gender Identity: AMS-MSS will ask the AMA to oppose mandated reporting of youth who question or express interest in exploring their gender identity. (MSS Res 18, I-18) (AMA Res 015, A-19, Adopted [H-65.959])

65.030MSS Sexual and Gender Minority Populations in Medical Research: AMA-MSS will ask the AMA to amend policy H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion and deletion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967
Our AMA: (1) supports the voluntary inclusion of a patient’s biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation/gender identity, sexual orientation, gender identity, and other sexual and gender minority traits such as differences/disorders of sex development for the purposes of research into patient and population health. (MSS Res 32, I-18) (AMA Res. 242, A-19, Appended [H-315.967])

65.031MSS Oppose Requirements of Hormonal Treatments for Athletes: AMA-MSS will ask the AMA to: (1) oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences in Sex Development (DSD) to be allowed to compete in alignment with their identity; and (2) oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions. (MSS Res 67, I-18) (AMA Res 019, A-19, Referred)

65.032MSS Patient-Reported Outcomes in Gender Confirmation Surgery: AMA-MSS will ask the AMA to: (1) support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender confirmation surgeries; and (2) support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender confirmation surgeries. (MSS Res 26, I-17) (AMA Res 004, A-18, Adopted [H-460.893])

75.00MSS Contraception

75.001MSS Mandatory Parental Notification for Minors Seeking Contraceptive Devices: AMA-MSS supports the concept that primary prevention of unplanned pregnancy, particularly among the young, is a public health priority; expressed concern that requiring notification and verification of contraceptive care to minors may increase the number of teenagers at risk of unplanned pregnancies by establishing a real or perceived barrier to a primary preventive health service. (MSS Res 21,
75.003MSS  

75.005MSS  
**Promotion of Emergency Contraception Pills:** AMA-MSS will ask the AMA to: (1) support public health education relating to emergency contraception pills (ECPs) by working in conjunction with the appropriate specialty societies and organizations to encourage the widespread dissemination of information on ECPs to the medical community, women’s groups, health groups, clinics, the public and the media; and (2) advocate programs that provide improved access to emergency contraception pills for women during after-hours need. (MSS Sub Res 54, I-98) (AMA Amended Res 403, A-99 Adopted [D-75.999]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (D-75.999 Rescinded: CSAPH Rep. 1, A-09) (Reaffirmed: GC Rep B, I-13)

75.007MSS  
**Preservation of HIV and STD Prevention Programs Involving Safer Sex Strategies and Condom Use:** AMA-MSS will ask the AMA to reaffirm its policy to reiterate that HIV and STD prevention education must be comprehensive to incorporate safer sex strategies including condom use, not just abstinence, and that these programs be culturally sensitive to sexual orientation minorities. (MSS Late Res 1, I-02) (AMA Amended Res 732, I-02, Adopted [D-20.994]) (Amended: MSS Rep C, I-07) (D-20.994 Rescinded: CCB/CLRPD Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

75.008MSS  
**Opposition to Sole Funding of Abstinence-Only Education:** AMA-MSS will ask the AMA to actively oppose increasing federal and state funding for abstinence-only education, unless future research shows its superiority over comprehensive sex education in terms of preventing negative health outcomes. (MSS Res 31, A-03) (AMA Amended Res 441, I-03 Adopted [H-170.968]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

75.009MSS  
**Ending Discrimination Against Contraception:** AMA-MSS will ask the AMA to support the concept of equity among all forms of prescription contraception in order to offer women the option of affordable contraceptives which would include support from state and federal agencies. (MSS Res 34, I-03) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-04) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

75.011MSS  
**Informed Consent with Regards to Advertising and Prescribing Contraceptives:** AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available. (MSS Rep B, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

75.012MSS  
**Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception:** That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling. (MSS 30, A-14) (Reaffirmation A-15; Appended: Res. 502, A-15 Adopted with Change in Title [H-75.987])

75.013MSS  
**Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement:** AMA-MSS will ask (1) that our AMA recognize the practice of
immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies, (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures. (MSS Res 10, I-15) (AMA Res 101, A-16 Adopted as Amended [ ])

90.000MSS Disabled


90.007MSS Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization: AMA-MSS (1) supports educating medical students and health care professionals on the societal discrepancies endured by the disabled population as well as services provided by post-secondary disability resource centers; and (2) will promote utilization of disability resource centers at the post-secondary level for students who meet the requirements established by those centers. (MSS Res 35, I-10) (Reaffirmed: MSS GC Rep D, I-15)

90.008MSS Support for Housing Modification Policies: AMA-MSS will ask the AMA to support legislation for health insurance coverage of housing modification benefits for: a) the elderly, and b) other populations including but not limited to the disabled, soon to be disabled, and other person(s) with physical and/or mental disability that require these benefits in order to mitigate preventable health conditions. (MSS COLA Rep A, A-19)

95.000MSS Drug Abuse


95.002MSS Methamphetamine Abuse: AMA-MSS will work to educate members on the health impacts of methamphetamine manufacture and abuse and will support national and state legislation that regulates pseudoephedrine availability and accessibility to prevent the use of pseudoephedrine for non-medical purposes. (MSS Res 22, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
95.003MSS  **Marijuana: Medical Use and Research**: AMA-MSS will ask the AMA to support reclassification of marijuana’s status as a Schedule I controlled substance into a more appropriate schedule. (MSS Res 2, A-08) (AMA Res 910, I-08 Referred) (Reaffirmed: GC Rep B, I-13)

95.004MSS  **Support for Drug Courts**: AMA-MSS will ask the AMA to (1) support the establishment of drug courts as an alternative to incarceration and as a more effective means of overcoming drug addiction for drug-abusing individuals convicted of nonviolent crimes; and (2) encourage legislators to establish drug courts at the state and local level in the United States. (MSS Res 29, I-11) (AMA Res 201, A-12 Adopted as Amended [H-100.955]) (Reaffirmed: MSS GC Report A, I-16)

95.005MSS  **Recognition of Addiction as Pathology, Not Criminality**: AMA-MSS supports encouraging government agencies to re-examine the enforcement-based approach to illicit drug issues and to prioritize and implement policies that treat drug abuse as a public health threat and drug addiction as a preventable and treatable disease. (MSS Res 31, I-11) (Reaffirmed: MSS GC Report A, I-16)

95.006MSS  **Comprehensive Evidence-Based Drug Treatment in Prisons**: AMA-MSS will ask the AMA to work with appropriate specialty societies to develop and promote legislative and policy initiatives that expand comprehensive evidence-based substance abuse treatment in federal, state and local prisons and jails. (MSS Res 38, A-12) (HOD Policies H-430.994 and H-430.997 Reaffirmed in Lieu of AMA Res 901) (Reaffirmed: MSS GC Report A, I-17)

95.007MSS  **Increased Advocacy for Needle Exchange Programs**: AMA-MSS will ask the AMA to amend policy H-95.958 by insertion as follows:

H-95.958 Syringe and Needle Exchange Programs

The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.


95.008MSS  **Cannabis and the Regulatory Void**: AMA-MSS believes that although cannabis is a mind-altering drug whose use may have unforeseen consequences; (1) federal and state governments should abolish all criminal penalties relating to consumption or possession of cannabis; (2) the sale of cannabis for medicinal use should be regulated according to evidence-based research; and (3) additional research should be encouraged. (MSS Res 27, I-12) (Modified: MSS Res 18, A-17)

95.009MSS  **Addressing Emerging Trends in Recreational Drug Abuse**: That our AMA (1) support the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (2) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse. (MSS Res 16, A-14) (Substitute AMA Res 901, I-14 Adopted with Change in Title [H-95.940])

95.010MSS  **Eliminating “Fail First” Policy in Addiction Treatment**: AMA-MSS will ask that our AMA advocate for the elimination of the “fail first” policy implemented by insurance companies for addiction treatment. (MSS Res 19, A-16)

95.011MSS  **Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis**: AMA-MSS will ask that our AMA work with state and local health departments to achieve the legalization and
implementation of facilities that provide a supervised framework and enhanced aseptic conditions for the injection of self-provided illegal substances with medical monitoring, with legal and liability protections for persons working or volunteering in such facilities and without risk of criminal penalties for recipients of such services. (MSS Res 08, A-17, Immediate Transmittal) (AMA Res 524, A-17, Substitute Resolution Adopted In lieu of Res 513 and 524 [H-95.925])

95.012MSS Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities: AMA-MSS will ask the AMA to advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (MSS Res 06, A-19)

95.013MSS Support Expansion of Good Samaritan Laws: AMA-MSS will ask our AMA to amend policy D-95.977 by insertion to read as follows:

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; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan laws.

(MSS Res 37, A-19)

95.014MSS Opposition to Lack of Evidence-Based Medicine in Drug Courts: AMA-MSS (1) supports the physician’s role within drug courts for developing specific pharmacological treatment for patients with substance use disorder, and (2) supports physician-patient shared decision-making in addiction treatment planning in all venues, including in the criminal justice system as it regards patients referred to drug courts and those serving probation and on parole. (MSS Res 37, A-18)

95.015MSS Opioid Treatment Programs Reporting to Prescription Monitoring Programs: AMA-MSS will ask the AMA to amend the policy Opioid Treatment and Prescription Drug Monitoring Programs, D-95.980 by deletion to read as follows:

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980

That our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

(MSS Res 76, I-17) (AMA Res 507, A-18, Referred)

100.000MSS Drugs

100.001MSS Ethical Concerns and Development of New Medications: AMA-MSS will ask the AMA to support the position that research, development, and submission for the Food and Drug Administration consideration of antiprogestins and other new medications be based predominantly on scientific evidence. (AMA Sub Res 252, A-89 Adopted [H-100.986]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)

100.004MSS AMA Support for the Use of Patient Controlled Analgesia (PCA): AMA-MSS will ask the AMA to support the use of Patient Controlled Analgesia (PCA), when not contraindicated, as one of several effective analgesic methods. (AMA Amended Res 510, A-92 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

100.005MSS Informational Campaign on Diethylstilbestrol - (DES): AMA-MSS will ask the AMA to: (1) encourage education on the consequences of diethylstilbestrol exposure so that medical students and health care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children; and (2) support research efforts on DES exposure and the future health of those affected. (MSS Amended Res 1, A-98) (AMA Amended Res 50, I-98 Adopted [H-100.970]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

100.007MSS Naloxone Administration and Heroin Overdose: AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opiate addiction and abuse places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opiate addiction; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine. (MSS Rep A, A-05) (AMA Amended Res 526, A-06 Adopted [D-95.987]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

100.008MSS Novel Antibiotics and Antimicrobial Resistance: AMA-MSS will ask the AMA to continue to monitor the spread of antibiotic resistance and, if deemed necessary, support mechanisms that would result in the timely development of novel antibiotics. Mechanisms should include a combination of push and pull incentives with legislation modeled after the Orphan Drug Act in conjunction with intensive educational efforts targeting physicians and patients. (MSS Rep F, A-08) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 513, A-09) (Reaffirmed: MSS GC Rep A, I-14)

100.009MSS Reporting of Adverse Drug Events: AMA-MSS will ask the AMA to (1) educate physicians about the distinction between adverse events and serious adverse events, as well as the importance of and ethical obligation to report serious adverse events; (2) work with relevant governmental agencies and private organizations to facilitate voluntary physician reporting of adverse drug and medical device events; and (3) encourage the FDA to investigate barriers to physician reporting of serious adverse events. (MSS Sub Res 19, I-09) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 513, A-10) (Reaffirmed: MSS GC Rep A, I-14)

100.010MSS Promoting Prevention of Fatal Opioid Overdose: AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11) (HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12) (Reaffirmed: MSS GC Report A, I-16)

100.011MSS Drug Shortages: AMA-MSS supports the Council on Science and Public Health Report 7, A-12, “Drug Shortages Update,” that contains the following recommendations:

1. Our AMA supports the recommendations of multiple stakeholders’ working in a collaborative fashion to implement these recommendations in an urgent fashion.
2. Our AMA will advocate that the U.S. Food and Drug Administration and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.
3. The Council on Science and Public Health continue to evaluate the drug shortage issue and keep the HOD informed about AMA efforts to address this problem.
4. Our AMA urges the development of a comprehensive federal report on the root causes of drug shortages. Such an analysis should include economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing (Sub MSS Res 41, A-12) (Modified and Reaffirmed: MSS GC Rep A, I-17)

100.012MSS

Support for the Use of Pain Contracts: AMA-MSS supports a physician’s discretionary utilization of pain contracts/agreements while prescribing opioids. (MSS Res 3, A-15)

100.013MSS

OTC Availability of Naloxone: AMA-MSS will ask the AMA to support the study of over the counter availability of naloxone. (MSS Res 33, A-15) (AMA Res 909, I-15 Adopted as Amended [H-95.932])

100.014MSS

Drug Pricing Reform: AMA-MSS (1) supports enabling Medicare and other federal health systems to negotiate drug prices with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies, and support states who wish to negotiate with pharmaceutical companies for their state-run health programs; and (2) supports legislation that requires increased transparency and public accessibility to drug manufacturing costs from all players in the drug supply production chain, including but not limited to: drug manufacturers, pharmaceutical company marketing information, pharmaceutical research and development costs and distribution companies. (MSS Res 21, I-15)

100.015MSS

Addressing the U.S. Drug Shortage Crisis: AMA-MSS will ask the AMA to support the repeal of the “Anti-Kickback Safe Harbor” for Group Purchasing Organizations. (MSS Res 1, I-15) (AMA Res 201, A-16 Referred for Decision)

100.016MSS

Educating Physicians and Young Adults on Synthetic Drugs: AMA-MSS will ask the AMA to amend AMA policy H-95.940 to read as follows:

Our AMA: (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor energy trends in illicit and legal synthetic drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of continuing medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (MSS Res 09, I-16) (AMA Res 507, A-17 CSAPH Rep 2 Adopted in lieu of Res 507)

100.017MSS

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

**Perinatal Addiction – Issues in Care and Prevention H-420.962**

Our AMA:

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

(MSS Res 07, A-17)

Research, Education and Awareness Regarding Non-Opioid Pain Management Treatments: AMA-MSS supports the efforts of the AMA Opioid Task Force and its goal to reduce opioid abuse. (MSS Res 35, A-17)

Advocating for Anonymous Reporting of Overdoses by First Responders and Emergency Physicians: AMA-MSS will ask the AMA to support non-fatal and fatal opioid overdose reporting to the appropriate agencies. (MSS Res 10, I-17)

Reforming the Orphan Drug Act: AMA-MSS will ask the AMA to (1) support legislation and policy efforts to reform the Orphan Drug Act by closing loopholes identified by the FDA in order to protect the Act’s original intent of promoting therapies targeting rare diseases; (2) support increased transparency in development costs, post-approval regulation, overall earnings, and off-label uses for pharmaceuticals designated as “Orphan Drugs”; and (3) support efforts to modify the exclusivity period of “Orphan Drugs” in order to increase access to these pharmaceutical drugs. (MSS Res 34-I-17)

Opposing the Classification of Cannabidiol as a Schedule 1 Drug: AMA-MSS will ask the AMA to support the reclassification of Cannabidiol (CBD) as a non-scheduled drug (MSS Res 64-I-17)

Ensuring Fair Pricing of Drugs Developed with the United States Government: AMA-MSS will ask our AMA to amend policy H-110.987 by insertion to read as follows:

Pharmaceutical Costs H-110.987

(1) Our AMA encourages the Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

(2) Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

(3) Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

(4) Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

(5) Our AMA encourages prescription drug price and transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

(6) Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

(7) Our AMA supports legislation to shorten the exclusivity period for biologics.
(8) Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drugs more affordable for all patients.

(9) Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

(10) Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

(11) Our AMA advocates for policies that prohibit price gouging on prescription medications when there are not justifiable factors or data to support the price increase.

(12) Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

(13) Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as an individual solution or in conjunction with other approaches.

(MSS Res 49, A-19)

100.024MSS Supporting Research into the Therapeutic Potential of Psychedelics: AMA-MSS will ask the AMA to 1) call for the status of psychedelics as Schedule 1 substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines; 2) given the high regulatory and cultural barriers, explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research; and 3) support and promote research to determine the benefits and adverse effects of long-term psychedelic use. (MSS CSI Rep A, A-19)

105.000MSS Drugs: Advertising


105.002MSS FDA Regulation of OTC Medication Advertising: AMA-MSS supports increased oversight of over-the-counter medication advertising, applying similar standards that are applied to prescription medication advertising. (MSS Sub Res 2, A-15)

105.003MSS Opposing Tax Deductions for Direct to Consumer Advertising: AMA-MSS opposes allowing costs for direct-to-consumer advertising of prescription medications, medical devices, and controlled drugs to be considered deductible business expenses for tax purposes. (MSS Res 05, A-16)
Pharmaceutical Advertising in Electronic Health Record Systems: AMA-MSS will ask the AMA to 1) encourage the Center for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in EHRs, on physician prescribing, patient safety, health care costs, and EHR access for small practices; and 2) study the ethics of direct to physician advertising at the point of care, including advertising in electronic health record systems. (MSS CHIT/CEQM Rep A, A-19)

**115.000MSS**  
**Drugs: Labeling and Packaging**

**115.001MSS** Fingerstick and Single-Use Point-of-Care Blood Testing Devices Should Not Be Used For More Than One Person: AMA-MSS will ask the AMA to encourage improved labeling of fingerstick and point-of-care blood testing devices such that it is clear that multiple-use fingerstick devices made for single patients are intended for use only on single patients. (MSS Res 44, I-10) (AMA Res 515, A-11 Adopted [H-480.951]) (Reaffirmed: MSS GC Rep D, I-15)

**115.002MSS** Advocacy for a System of Improved and Standardized Instructions for Drug Labels in order to Promote Health Literacy and Patient Well-Being: AMA-MSS will ask the AMA to (1) encourage the Food and Drug Administration and other appropriate third parties to consider the implementation of a system of written medication instructions with strongly correlating standardized pictorial representations that adequately represent the instructions in order to allow individuals of low literacy to clearly comprehend directions for and significance of medication use; and (2) encourage the Food and Drug Administration (FDA) and other appropriate third parties to include on all prescribed medication labels, if the patient so desires, the reason for which the medication was prescribed. (MSS Res 24, A-12) (AMA Sub Res 904, I-12 Adopted [D-115.990]) (Reaffirmed: MSS GC Report A, I-17)

**115.003MSS** Addressing Drug Overdose and Patient Compliance with Targeted Pharmaceutical Packaging Efforts: AMA-MSS will ask the AMA to support research into novel and affordable pharmaceutical packaging in attempts to increase ease of use, improve patient compliance, and decrease abuse potential. (MSS Res 22, I-14) (AMA Res 501, A-15 Adopted as Amended [H-115.967])

**120.000MSS**  
**Drugs: Prescribing and Dispensing**


**120.003MSS** Advocacy for Research into the Effects of Psychotropic Drugs in Children: AMA-MSS will ask the AMA to: (1) work in conjunction with the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and other relevant organizations to encourage increased funding for research into the safety and efficacy of psychotropic medications in children, especially those under 4 years of age, adolescents, and young adults; (2) establish diagnostic criteria for use of these medications in children, adolescents, and young adults; (3) promote incentives to create the infrastructure necessary to carry out studies related to the effects of psychoactive drugs in children, adolescents, and young adults, expressly to train qualified clinical investigators in pediatrics, child psychiatry, and pharmacology; and (4) promote efforts to educate physicians about the appropriate use of psychotropic medications in the treatment of children, adolescents, and young adults. (MSS Amended Res 1, A-00) (AMA Amended Res 504, I-00 Adopted [D-60.995]) (Reaffirmed: MSS Rep
Tracking and Punishing Distributors of Counterfeit Pharmaceuticals: AMA-MSS will ask the AMA to support the Food and Drug Administration’s efforts to research a uniform tracking system for pharmaceuticals and legislation making the production and distribution of counterfeit pharmaceuticals a felony. (MSS Res 35, I-03) (AMA Amended Res 924, I-03 Adopted [D-100.988]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)


Patient Access to Legal Pharmaceuticals under Pharmacist Conscientious Objector Policy: AMA-MSS: (1) supports the American Pharmaceutical Association in ensuring that pharmacies and pharmacists set up systems which guarantee patient access to legal pharmaceuticals without unnecessary delay or interference; and (2) supports legislation which requires pharmacies to fill legally written prescriptions or to provide timely alternative access without interference. (MSS Sub Res 23, A-05 Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Decreasing Epinephrine Auto-Injector Accidents and Misuse: AMA-MSS will ask the AMA to (1) encourage physicians to review standard epinephrine auto-injector administration protocol with patients upon initial prescription and on follow-up visits; and (2) encourage improved product design and labeling of epinephrine auto-injectors. (MSS Res 19, A-10) (AMA Res 513, A-11 Adopted [H-115.968]) (Reaffirmed, MSS GC Rep D, I-15)

Restrictions on Use of Physician Prescribing Data for Commercial Purposes: AMA-MSS (1) supports limiting the use of physician prescribing data from any and all sources for commercial purposes, including its use by pharmaceutical companies; and (2) supports the availability of physician prescribing data to organizations using it for public health research, law enforcement, adverse effects reporting, and all other noncommercial purposes. (MSS Res 40, A-11) (Reaffirmed: MSS GC Report A, I-16)

Aligning Prescription Medication Renewals: AMA-MSS will ask the AMA to encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the travel barriers for prescription acquisition. (MSS Res 16, A-12) (AMA Res 801, I-12 Adopted [H-120.952]) (Reaffirmed: MSS GC Report A, I-17)

Personalized Medication Cards: That our AMA support third parties in researching the effectiveness of personalized medication cards, written in a variety of languages for low literacy target audiences, in increasing medication adherence and improving health outcomes. (MSS Res 14, A-14) (AMA Res 906, Adopted as Amended with Change in Title [H-373.993])

Prior Authorization Reform: AMA-MSS supports prescription prior authorization reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, and exceptions for urgent care access. (MSS Res 13, I-15)
Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder: Our AMA-MSS will ask the AMA to study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine for treatment of Opioid Use Disorder. (MSS Res 02, I-16) (AMA Res 506, A-17 Adopted as Amended [D-95,972] and Additional Second Resolve Referred for Decision)

Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs: AMA-MSS will ask that our AMA work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959. (MSS Res 42, A-17)

Equalizing Reimbursement for Psychotherapy and Drug-Therapy: AMA-MSS supports comparable reimbursement rates per unit of time spent with patients for physician provided psychotherapy and pharmacotherapy where comparable efficacy has been demonstrated. (MSS Res 80-I-17)

Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians: AMA-MSS will ask the AMA to support the creation of national benzodiazepine-specific prescribing guidelines for physicians. (MSS Res 50, A-19)

Emergency Medical Services

Use of Automatic External Defibrillators: AMA-MSS will ask the AMA to support legislation for the increased use of automatic external defibrillators (AEDs) for the purpose of saving the life of another person in cardiac arrest provided that:

(1) A person or entity who acquires an automatic external defibrillator ensures that: (A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer’s operational guidelines; and (C) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible.

(2) Any person or entity who acquires an automatic external defibrillator is encouraged to register the existence and location of the defibrillator with the emergency communications district or the ambulance dispatch center of the primary provider of emergency medical services where the automatic external defibrillator is to be located. (MSS Sub Res 12, A-98) (AMA Res 503, I-98 Referred) (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Decreasing Emergency Department Overcrowding:
(1) AMA-MSS supports legislation that addresses the issue of emergency department overcrowding and patient boarding.

(2) AMA-MSS will ask the AMA to work with state and federal governments, including agencies such as the Centers for Medicare and Medicaid Services and the U.S. Office of Preparedness and Emergency Operations, to develop guidelines and increase incentives for hospitals to reduce emergency department overcrowding. (MSS Sub Res 2 Adopted in Lieu of MSS Res 2 and MSS Res 7, I-08) (CMS Rep 3, A-09, Adopted in Lieu of AMA Res 719, A-09 [H-130.940]) (Reaffirmed: MSS GC Rep A, I-14)

Air Ambulance Regulations and Reimbursements: AMA-MSS will ask that our AMA and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance
services, including barriers to adequate competition, reimbursement, and quality improvement. (MSS Res 16, A-17)

130.006MSS Physician Use of Emergency Lights in Responding to Medical Emergencies: AMA-MSS will ask the AMA to encourage research on the effect of physician use of emergency lights in private vehicles when responding to medical emergencies, which should include effects on response time, patient outcomes and physician motor vehicle safety. (MSS Res 35, A-18)

135.000MSS Environmental Health


135.003MSS Recycling in the Medical Community: AMA-MSS will ask the AMA to encourage the medical community to 1) initiate programs to recycle paper, aluminum cans, and bottles to show their commitment to improving the environment; and 2) use recyclable products in lieu of substances shown to be deleterious to the environment. (AMA Sub Res 169, I-89, Adopted [H-135.975]) (Reaffirmed: MSS Rep D, I-99) (H-135.975 Rescinded: CSAPH Rep. 1, A-10) (Reaffirmed: MSS GC Report A, I-16)


135.011MSS Providing Safety-Type Needles for Use in Health Care Settings: AMA-MSS (1) supports efforts to require all health care settings to provide safety-type needles (such as re-sheathable winged steel needles, bluntable needles, or needles with hinged recapping sheaths) as viable alternatives to conventional hypodermic needles for the use of staff and students and (2) recommends that all health care institutions educate and encourage injured persons to report their needle stick injuries to the proper sources so that they might receive appropriate diagnostic and therapeutic care. (MSS Amended Res 33, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

135.012MSS Toward Environmental Responsibility: AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16)
Statement of Sustainability Principles: AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15)

Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability: AMA-MSS will ask our AMA (1) amend policy H-135.949 by addition and deletion to read as follows:

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

(2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. (MSS Res 23, A-17)

AMA Policy on Investing in the Fossil Fuel Industry: AMA-MSS supports (1) the American Medical Association, Foundation, and any affiliated corporations, to work in a timely and fiscally responsible manner to end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, to choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers. (MSS Res 33, A-17)

Mitigating Food Waste through Food Recovery: AMA-MSS will ask the AMA to (1) prioritize sustainability and mitigation of food waste in vendor and venue selection and (2) encourage vendors and relevant third parties to practice sustainability and mitigate food waste through donation. (MSS Res 08, I-17)

Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water: AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (MSS Res 02, A-19)

Be the Change: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership: AMA-MSS will ask the AMA to shift existing all-inclusive paper JAMA to opt-in paper JAMA subscriptions by the year 2020, still giving students an option to receive paper JAMA, while reducing AMA paper waste, supporting a green initiative, and saving cost. (MSS Res 45, I-18) (AMA Res 615, A-19, Referred)
140.002MSS  **Bioethical Determinations**: It is the position of the AMA-MSS that (1) In order to facilitate the training of physicians better equipped to assist patients in dealing with bioethical issues, courses in humanities, social sciences, and specifically bioethical issues should be included by medical schools in their recommendations for college courses. (2) More time should be integrated into the medical and post graduate training programs for exposure to bioethics, emphasizing clinical problems. (3) The establishment of standing or ad hoc committees at hospitals, which could facilitate the ethical decisions required to be made by patients and physicians, should be pursued. (4) Physicians should provide patients with medical information necessary to make autonomous informed decisions, should solicit informed consent, and should realize that a significant aspect of their therapeutic role is to assist patients in either making autonomous decisions or restoring their autonomy. The physicians should act with compassion and empathy toward all involved parties. (5) Physicians in organized medicine should take an active role in encouraging legislation that would define the rights of the competent patient to make decisions regarding his or her own health care and the determination of who makes decisions for health care in the non-competent patient. (MSS Rep C, I-82 Attachment 4) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

140.003MSS  **Hospital Ethics Committees**: AMA-MSS will ask the AMA to take an active role consistent with its existing policy and encourage the continued development of hospital-based multi-disciplinary review committees designed to address ethical concerns, including the health care of persons with disabling conditions. (AMA Res 157, A-84 Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

140.007MSS  **AMA-MSS Support of Advance Directives**: (1) AMA-MSS affirms the need for advance directives for all patients, including young adults, and will provide its members with information about advance directives, and recommends medical students complete their own; (2) AMA-MSS will ask the AMA to encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship; (3) AMA-MSS will ask the AMA to (a) recommend that advance directives completed by a patient be placed in a prominent area of the patient’s medical record; and (b) recommend the inclusion of information on and eligibility requirements pertaining to organ and tissue donation in any advanced directive; (4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients. (MSS Res 27, I-90, MSS Sub Res 59, I-98, MSS Res 20, I-09, MSS GC Rep A, I-06, MSS GC Rep I, I-84, Consolidated: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep A, I-14) (Modified: MSS Res 04, I-16)

140.012MSS  **Increasing Prevalence and Utilization of Ethics Committees**: AMA-MSS will ask the AMA to encourage collaboration among health care facilities without ethics committees to develop flexible, efficient mechanisms of ethics review that divide the burden of committee functioning among participating health care facilities. (MSS Res 15, I-96) (AMA Res 9, A-97 Referred) (Reaffirmed: MSS Rep B, I-01) (Re reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11)

140.013MSS  **Out-of-Hospital Do-Not-Resuscitate (DNR) Orders**: AMA-MSS supports the rights of terminally and chronically ill patients to have their DNR orders honored by emergency personnel in all out-of-hospital settings in so far that adequate proof and documentation of the patients’ DNR status can be provided in an emergency situation (i.e., medic alert bracelet, etc.). (MSS Amended Sub Res 4, A-97) (Reaffirmed: MSS GC Rep B, I-02) (Reaffirmed: MSS GC Rep C, I-07) (Modified: MSS GC Rep C-I-12) (Reaffirmed: MSS GC Rep A, I-17)
140.019MSS  **Supporting the Establishment of Guidelines Regarding Online Professionalism:** AMA-MSS will ask the AMA to (1) initiate discussions with partner organizations towards developing a consensus for online professionalism in the medical community that may be used by medical schools to guide the development of policies outlining expectations of professionalism on the Internet for students; and (2) during its efforts to update and modernize the *AMA Code of Medical Ethics*, include a section regarding online professionalism. (MSS Res 12-I-09) (AMA Res 10-I-09, Adopted [D-478.985]) (D-478.985 Rescinded: CCB/CLRDP Rep. 1, A-13) (Reaffirmed: MSS GC Rep A, I-14)

140.020MSS  **Increasing Physician Presence in Online Social Networks:** AMA-MSS recommends that physicians, medical students, and other members of the medical community educate themselves both about the advantages and increased communication opportunities provided by social networks, but also about the liability and patient confidentiality issues presented. (MSS Res 12, A-10) (Reaffirmed, MSS GC Rep D, I-15)

140.023MSS  **Responsible Biomedical and Bioethics Journalism:** AMA-MSS will ask the AMA to (1) encourage responsible biomedical and bioethics journalism; and (2) support the efforts of the Association of Health Care Journalists and other organizations to promote responsible biomedical and bioethics journalism. (GC Rep B, A-10) (AMA Amended Res 606, I-10 Adopted [H-140.854]) (Reaffirmed, MSS GC Rep D, I-15)

140.024MSS  **Encouraging Standardized Advance Directives Forms within States:** AMA-MSS will ask the AMA to encourage state societies to develop a standardized form of advance directives for use by physicians and other health care providers as a template to discuss end-of-life care with their patients. (MSS Sub Res 18, A-11) (AMA Res 5, I-11 Adopted as Amended [H-85.957]) (Reaffirmed: MSS GC Report A, I-16)

140.025MSS  **Regulations on the Patenting of Endogenous Human DNA:** AMA-MSS will ask the AMA to oppose the patenting of endogenously occurring human DNA or RNA sequences, including specific alleles of such sequences found anywhere within the human population, or DNA and RNA products derived from these sequences. (MSS Res 47, I-11) (Reaffirmed Existing AMA Policy with Amendment in Lieu of Res 504, A-12) (Reaffirmed: MSS GC Report A, I-16)

140.026MSS  **Assisted Suicide:** AMA-MSS recognizes that situations may exist where it would be ethically acceptable for patients to choose to end their own lives. (MSS Res 17, I-12) (Reaffirmed: MSS GC Report A, I-17)

140.027MSS  **Standardization of Medical Ethics Core Competencies for Undergraduate Medical Education:** AMA-MSS will as the AMA to (1) recognize the importance of addressing the disparity between current outcomes and the ideal status of undergraduate medical education in bioethics and humanities; (2) in partnership with appropriate AMA-MSS bodies, leverage its internal resources and its relationships with professional society stakeholders to create suggested guidelines for undergraduate medical education of bioethics and humanities guided by LCME requirements and the ASBH Task Force; and (3) advocate for the national adoption of a set of suggested guidelines for undergraduate medical education in bioethics and humanities by allopathic and osteopathic medical schools. (MSS Res 6, A-13) (AMA Policy H-295.961 Reaffirmed in Lieu of AMA Res 902, I-13)

140.028MSS  **Solitary Confinement:** That our AMA (1) oppose the use of solitary confinement for juveniles or the mentally ill regardless of circumstance; (2) oppose the use of solitary confinement for disciplinary purposes; and (3) support that isolation for clinical or therapeutic purposes must be conducted under the recommendation and supervision of a physician. (MSS Res 2, A-14) (AMA Res 3, I-14 Adopted with Change in Title [H-60.922])

140.029MSS  **Ethical Parameters for Recommending Mobile Medical Applications:** AMA-MSS ask the AMA to examine the issues related to physicians recommending medical software and apps to patients,
especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically. (MSS Res 13, A-15) (AMA Res 002, I-15 Reaffirmation)

140.030MSS Ethical Physician Conduct in the Media: AMA-MSS (1) supports a report on the professional and ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) urges the AMA release a statement affirming the professional and ethical obligation of physicians in the media to provide quality medical advice transparent to supporting evidence and conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media; and (3) supports a study existing and potential disciplinary pathways for physicians who violate ethical responsibilities through their communication on a media platform. (MSS Res 25, A-15)

140.031MSS Accommodations for Treatment of Medical Students and Residents: AMA-MSS ask the AMA to study the power-dichotomy between physician and trainee in their position on peers as patients. (MSS Late Res 1, A-15) (AMA Res 003, I-15 Adopted as Amended [D-405.983, then H-295.858])

140.032MSS Study of the Current Uses and Ethical Implications of Expanded Access Programs: AMA-MSS will ask (1) that our AMA study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies; and (2) that our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies. (MSS Res 08, A-16)

140.033MSS Addressing the Importance of Advance Directive Planning and Education for Medical Students: Our AMA-MSS supports undergraduate medical education on end-of-life care, including teaching advance directive planning as a clinical skill through simulation and skills practice, in addition to established didactic modalities. (MSS Res 04, I-16)

140.034MSS Physician-Aid-In-Dying: AMA-MSS (1) supports protections for physicians who participate in physician aid-in-dying in states where physician aid-in-dying is legal and (2) encourages use of the term “physician aid-in-dying” instead of “physician-assisted suicide.” (MSS Res 06 , I-16)

140.035MSS Proposing Consent for De-Identified Patient Information: AMA-MSS will ask the AMA to study the handling of de-identified patient information by covered entities for third party commercial use and report findings and recommendations back to the AMA House of Delegates (MSS Res 01, I-17) (AMA BOT Rep 26, A-19, Referred)

140.036MSS Expansion of the Goldwater Rule: AMA-MSS considers it unethical for a physician to offer a professional opinion about specific medical cases on individual patients unless he or she has conducted an examination and has been granted proper authorization for a public media statement. (MSS Res 89-I-17)

140.037MSS Non-Therapeutic Gene Therapies: AMA-MSS will ask the AMA to partner with relevant institutions to encourage the development of safety guidelines, regulations, and permissible uses of performance enhancing, non-therapeutic gene therapies. (MSS Res 54, I-17) (AMA Res 506, Referred)

145.000MSS Firearms: Safety and Regulation

145.001MSS Handgun Violence: The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard:
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(1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

145.004MSS Prevention of Unintentional Firearm Accidents in Children: AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety. (AMA Amended Res 165, I-89 Adopted [H-145.990]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)


145.011MSS Gun Safety Counseling in Undergraduate Medical Education: AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976])

145.012MSS Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks: AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks. (MSS Res 15, A-13)

145.013MSS Strengthening our Gun Policies on Background Checks and the Mentally Ill: AMA-MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13)

145.014MSS Preventing Fire-Arm Related Injury and Morbidity in Youth: AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14)

145.015MSS Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers: AMA-MSS supports legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers,
and persons charged with domestic violence and intimate partner violence even if no legal relationship exists. (MSS Res 03, A-18)

145.016MSS Opposition to Armed Campuses: AMA-MSS opposes an increase of firearms on school campuses. (MSS Res 16, A-18)

145.017MSS Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21: AMA-MSS support bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21. (MSS Res 18, A-18)

145.018MSS Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings: AMA-MSS will ask the AMA to encourage the Center for Disease Control, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (MSS Res 40, A-18)


145.020MSS Opposing Unregulated, Non-Commercial Firearm Manufacturing: AMA-MSS will ask the AMA to (1) support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and (2) issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue. (MSS Res 07, I-18, HOD I-18 Adopted)

150.000MSS Foods and Nutrition


150.002MSS Revision of Dietary Guidelines for Americans: AMA-MSS will ask the AMA to: (1) support alterations of “Dietary Guidelines for Americans” only when such alterations are based upon valid medical and scientific principles, and without regard to the economic concerns of the food industry; and (2) recommend that any panel sitting in review of “Dietary Guidelines for Americans” should appoint its membership to avoid possible conflict of interest in accordance with the Federal Advisory Committee Act (5 U.S.C App. 1, Section 5C). (AMA Res 130, A-83, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

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

150.004MSS Food Substitutes: AMA-MSS will ask the AMA to continue to monitor ongoing studies and future developments concerning substitutes for fat, flour and butter so that physicians can be informed
about potential health risks or benefits to their patients before these products are released to the public market. (AMA Res 176, A-88 Adopted [H-150.976]) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)


150.012MSS  Allergic Reactions in Schools and Airplanes: AMA-MSS will ask the AMA to recommend that (1) all schools provide increased student education on the danger of food allergies; (2) all schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration, be trained and certified in the indications for and techniques of their use; and (3) all commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use. (MSS Res 33, A-03) (AMA Amended Res 415, A-04 Adopted [H-440.884]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

150.013MSS  Mercury in Food as a Human Health Hazard: (1) AMA-MSS will ask the AMA to (a) encourage that testing of mercury content in food, including fish, be continued by appropriate agencies, and laboratory reporting of results of mercury testing be updated and consistent with current Environmental Protection Agency and National Academy of Sciences standards; (b) encourage the Food and Drug Administration to determine the most appropriate means of testing and labeling of all foods, including fish, to determine mercury content; and (c) encourage that the results and advisories of any mercury testing of fish should be readily available where fish are sold, including labeling of packaged/canned fish. (2) AMA-MSS supports the AMA encouraging physicians to educate their patients about the potential dangers of mercury toxicity in some food and fish products, especially those that are well documented to contain mercury, and to advise pregnant women to limit and parents to limit their children’s consumption of such products. (MSS Sub Res 34, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

150.014MSS  Healthy Food Options in Hospitals: AMA-MSS will ask the AMA to encourage that healthy food options be available, at reasonable prices and easily accessible, on hospital premises. (MSS Res 21, I-03) (AMA Res 410, A-04 Adopted [H-150.949]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

150.015MSS  Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants and Schools: AMA-MSS will ask the AMA to (1) support the adoption of regulations by the U.S. Food and Drug Administration requiring restaurants with menu items that are standard to multiple locations provide standard nutrition labels for all applicable items, available to their customers on request and (2) support the adoption of regulations by the U.S. Food and Drug Administration requiring all restaurants, school, and work cafeterias to have ingredient lists and nutritional information, including total fat, trans fat, sugar content, and sodium, for all menu items, available to their customers on request. (MSS Res 22, I-03) (AMA Sub Res 411, A-04 Adopted in Lieu of Res 411 and 430 [H-150.948]) (Reaffirmed: MSS Rep E, I-08) (Amended: MSS Res 31, A-11) (AMA Res 914, I-11 Referred) (Reaffirmed: MSS GC Report A, I-16)

150.016MSS  Folic Acid Fortification of Grain Products: AMA-MSS will ask the AMA to: (1) urge the Food and Drug Administration to recommend the folic acid fortification of all grains marketed for human consumption, including grains not carrying the “enriched” label; and (2) write letters to domestic and international producers of corn grain products, including masa, nixtamal, maize, and pozole, to

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

150.018MSS Food Stamp Incentive Program: AMA-MSS will ask the AMA to support legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables. (MSS Res 16, I-06) (Res 405, A-07 Adopted [D-150.983]) (Reaffirmed: GC Rep C, I-11) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Rep A, I-16)

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

150.021MSS Accurate Reporting of Fats in Nutritional Labels: AMA-MSS will ask the AMA to urge the FDA to use the most accurate and scientific processes to measure the fat content in foods, particularly trans fats and saturated fats, and that the most accurate fat content information based on these processes be included on food labeling. (MSS Sub Res 29, I-09) (AMA Res 412, A-10 Adopted [H-150.939]) (Reaffirmed: MSS GC Rep A, I-14)

150.022MSS Support for Fees and Taxes on Non-Alcoholic Beverages Containing Caloric Sweeteners: AMA-MSS will (1) support and advocate for legislation and policies for increased fees and/or taxes on non-alcoholic beverages containing caloric sweeteners; and (2) support the exclusive use of revenue generated from taxes on non-alcoholic beverages containing caloric sweeteners for funding of public health programs designed to combat obesity or public health programs that promote good nutrition. (MSS Res 30, I-10) (Reaffirmed: MSS GC Rep D, I-15)

150.023MSS Price Parity in Fast Food Children’s Meals: AMA-MSS will ask the AMA to (1) encourage fast food restaurants to establish price parity between traditional side items and alternative, more healthful options in children’s meals; and (2) work directly with the White House’s Let’s Move Program to support the fast food industry in establishing price parity between traditional side items and alternative, more healthful options in children’s meals. (MSS Res 34, I-10) (AMA Sub Res 402 Adopted in Lieu of AMA Resolutions 407 and 402, A-11 [H-150.935 and D-150.977]) (Reaffirmed: MSS GC Rep D, I-15)

150.024MSS Opposition to Exclusivity Agreements between Junk Food Vendors and Public Schools: AMA-MSS will ask the AMA to oppose exclusivity agreements between school districts and food and beverage vendors unless those agreements contain provisions mandating that vendors predominantly provide healthful food choices that contribute to the nutritional needs of students. (MSS Res 38, I-10) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 408, A-11)

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


150.027MSS Harms and Benefits of Vitamin and Mineral Supplements: AMA-MSS (1) advocates for increased education and awareness regarding the harms and benefits of vitamin and mineral supplements; and (2) supports the study of vitamin and mineral supplement use in primary prevention of chronic disease. (MSS Res 38, A-14)

150.028MSS Increasing Healthy Food Choices Among Families Supported by the Supplemental Nutrition Assistance Program: AMA-MSS will ask the AMA to advocate for positive financial incentives to encourage healthier food purchases for Supplemental Nutrition Assistance Program participants. (MSS Res 35, A-14) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 905, I-14)

150.029MSS Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Vendor Programs: AMA-MSS will ask the AMA to support expanding the use of current state and federal food assistance programs (e.g. Supplemental Nutrition Assistance Program; Special Supplemental Nutrition Program for Women, Infants, and Children Fruit and Vegetable Cash Value Voucher; and the US Farm Bill) to include purchasing fruits and vegetables from licensed and/or certified healthy mobile produce vendors. (MSS Res 12, I-14) (Existing Policy Reaffirmed in Lieu of AMA Res 405, A-15)

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

150.031MSS Standardizing the Use of Expiration Dates on Food: AMA-MSS supports the principle that food dating labels be directed towards consumers in addition to retailers. (MSS Res 17, A-16)

150.032MSS Defending Federal Child Nutrition Programs: AMA-MSS will ask that our AMA (1) oppose legislation that reduces or eliminates access to federal child nutrition programs; and (2) reaffirm H-150.962 Quality of School Lunch Program. (MSS Res 09, A-17)

150.033MSS Federal Agricultural Subsidy Reform: AMA-MSS supports (1) efforts to limit the consumption of foods and beverages that contain added sweeteners by changes to the federal agricultural subsidies system; and (2) the adjustment of federal subsidies toward the preferential subsidization of crops and food products that are consistent with evidence based guidelines for good nutrition and healthy eating patterns. (MSS Res 30. A-17)

150.034MSS Identifying and Addressing Food Insecurity and Food Deserts Nationwide: AMA-MSS supports (1) research on the impact of factors influencing functional access to food including but not limited to
gentrification, transportation, and crime rates on the development of food deserts; (2) the creation of new tools aimed at identifying food deserts taking into account cost of food in geographically accessible stores or modification of existing tools for identification of food deserts to include consideration of affordability in the establishment of accessibility of healthy food sources; and (3) current efforts by the United States Department of Agriculture in the incorporation of nutrition education programs focusing on sustainable food sourcing and the impact of healthy foods on overall well-being including but not limited to those involving school and community garden building and education on healthy eating habits. (MSS Res 46, A-17)

150.035MSS Regulating Front-Of-Package Labels on Food Products: AMA-MSS will ask the AMA to (1) support additional FDA criteria that limit the amount of added sugar a food product can contain if it carries any front-of-package label advertising nutritional or health benefits and (2) support the use of front-of-package warning labels on foods that contain excess added sugar. (MSS Res 14, A-18)

150.036MSS Support of the Supplemental Nutrition Assistance Program (SNAP) Education Programs and Research: AMA-MSS (1) supports nutrition education programs for Supplemental Nutrition Assistance Program (SNAP) recipients and (2) opposes changes to SNAP that would increase food insecurity such as rigid work requirements or categorical exclusion of individuals who receive SNAP benefits based on their income level. (MSS Res 17, A-18)

150.037MSS Utilizing Food Insecurity Screenings in the Emergency Medical Setting to Identify at Risk Individuals: AMA-MSS will study the effectiveness of food prescriptions and hospital-based food assistance programs for those patients identified as food insecure. (MSS Res 51 I-18)

150.038MSS Eliminating Recommendations to Restrict Dietary Cholesterol and Fat: AMA-MSS will ask the AMA to amend AMA Policy H-150.944, “Combating Obesity and Health Disparities,” by deletion to read as follows:

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and non-dairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol, healthful foods and beverages. (MSS Res 40, I-18) (AMA Res 431, A-19, Not Adopted)

150.039MSS Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities: AMA-MSS will ask the AMA to (1) establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations; (2) amend H-60.972 by addition and deletion to read as follows:

Banning Food Commercials Aimed at Children H-60.972

(1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children; and

(2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations; and

(3) work with appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations. (MSS Res 67, I-17) (AMA Res 409, Adopted with Title Change [H-60.972], Food Advertising Targeted to Youth)
150.040MSS  Efficacy of Food Prescriptions and Hospital-Based Food Assistance Programs in Addressing Food Insecurity in the U.S.: AMA-MSS supports evidence-based methods of addressing food insecurity. (MSS CGPH Report A, A-19)

155.000MSS  Health Care Costs

155.001MSS  Listing of Hospital Charges: AMA-MSS will ask the AMA to: (1) recommend that all hospitals accredited by the Joint Commission provide their medical students, house-staff, and attending physicians with a list of commonly ordered diagnostic tests and prescribed medications with their corresponding costs to patients; and (2) recommend that such charges be included on all reporting result sheets and requisition forms. (AMA Amended Res 75, I-81 Adopted [D-155.990]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


155.003MSS  Price Transparency in Health Care: AMA-MSS supports legislation that requires insurance providers to provide an online resource for patients and physicians to calculate charges and out-of-pocket expenses associated with investigations and therapies in an effort to better educate patients and physicians on health care costs, equip patients to recognize value in health care, empower patients to participate in the spending of their health care dollars, and promote one-time and long-term patient savings in an effort to reduce economic strains on health care systems. (MSS Amended Res 8, A-09) (Reaffirmed: MSS GC Rep A, I-14)

155.004MSS  Advocating for Research on Physician-Initiated Conversations About Treatment Cost: That our AMA (1) support the conduction of controlled studies to determine if conversations about cost with patients have any meaningful change on various measures of health outcomes, including but not limited to quality of treatment decisions, liability, and patient satisfaction; and (2) support studies to determine if physicians or health professionals are the appropriate party to initiate such conversations. (MSS Res 18, A-14)

155.005MSS  Public Access to Chargemasters: AMA-MSS supports legislation requiring health-care institutions to provide public online access to their complete and current chargemaster in a searchable, consumer-friendly format that includes reference codes, descriptions, and prices. (MSS Res 04, A-17)


155.007MSS  Increasing Accessibility to Adult Incontinence Products: AMA-MSS will ask the AMA to support increased access to medically-recognized adult incontinence products through means including, but not limited to Medicare coverage. (MSS Res 24, A-18) (AMA Res 908, I-18, Adopted [H-155.955])

160.000MSS  Health Care Delivery
160.001MSS  Support of Community Health Clinics with Student Involvement: AMA-MSS will ask the AMA to:
(1) endorse the efforts of existing community health clinics with student involvement offering minimal cost, quality primary care; and (2) encourage county and state medical societies to work with medical universities, private practitioners, local health departments, and regional charities to develop more community health clinics of this orientation. (AMA Res 76, A-82 Not Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 50, A-18)


160.009MSS  Complete Federal Responsibility for Medical Translation Services: AMA-MSS believes that neither physicians nor patients should be expected to fund translation services for their patients as Department of Health and Human Services’ policy guidance currently requires. (MSS Res 30, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: MSS GC Report B, I-13)

160.012MSS  Readability of Medical Notices of Privacy Practices: AMA-MSS will ask the AMA to (1) continue to support physician efforts to provide Notices of Privacy Practices at an appropriate reading level and in a language appropriate to the patient population served; and (2) make available on its Web site a link to the Health Resources and Services Administration document, Plain Language Principles and Thesaurus for Making HIPAA Privacy Notices More Readable. (MSS Sub Res 9, A-09) (AMA Res 8, I-09 Adopted [H-190.958]) (Reaffirmed: MSS GC Rep A, I-14)

160.013MSS  Adoption of a Universal Exercise Database and Prescription Protocols for Obesity Prevention: AMA-MSS will ask the AMA to (1) collaborate with federal agencies and professional health organizations such as the American Heart Association and the American College of Sports Medicine to develop an independent meta-database of evidence-based exercise guidelines to assist physicians and other health professionals in making exercise prescriptions; and (2) support longitudinal research on exercise prescription outcomes in order to further refine prescription-based exercise protocols. (MSS Res 18, I-09) (AMA Res 415, A-10 Adopted [D-470.991]) (D-470.991 Rescinded: BOT Rep 10, A-14) (Reaffirmed: MSS GC Rep A, I-14)
Recognizing the Important Role of Physician Extenders in the Multidisciplinary Patient Care Team:
AMA-MSS (1) recognizes the importance of nurses, nurse practitioners, and physician assistants to the multidisciplinary patient-care team; (2) recognizes that the physician is the leader of the multidisciplinary patient care team, and that there are distinct differences in training, both in time and content, between physicians and physician extenders; and (3) supports the patient centered medical home model and the role of physicians therein as the primary medical decision makers. (MSS Res 9, A-10) (AMA Amended Res 208, I-10 Adopted [H-310.913]) (Reaffirmed, MSS GC Rep D, I-15)

Physician Extenders: (1) AMA-MSS opposes any legislation that seeks to expand the scope of practice of physician extenders beyond the level of expertise their training provides, and without the appropriate oversight of a physician; (2) AMA-MSS will ask the AMA to (a) support innovative reimbursement strategies for primary care physicians that reward the use of physician extenders to meet demand for health care services by increasing capacity for delivering care; (b) engage societies of physician extenders to develop consensus recommendations for scope of practice and physician oversight as a means to guide discussions in state and federal legislative bodies; and (c) oppose, in academic environments, payment models for physician extenders that interfere with graduate medical training, such as productivity bonuses and surgical assisting fees. (MSS Res 17, A-10) (Reaffirmed, MSS GC Rep D, I-15)

Promoting Internet-Based Electronic Health Records and Personal Health Records: AMA-MSS will ask the AMA to (1) advocate for the integration of provider and hospital electronic health records (EHRs) with Internet-based personal health records (PHRs) as an option for patients; and (2) advocate as a priority for all Internet-based PHRs to be fully HIPAA- compliant. (MSS Res 15, A-10) (AMA Res 809, I-10 Referred) (Reaffirmed: MSS GC Rep A, I-14)

Study of Interpreter Mandate: AMA-MSS will ask the AMA to evaluate the impact on a physician practice of any federal mandate that requires an interpreter be present for patients who cannot communicate proficiently in English. (MSS Res 20, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Investigating Cost-Saving, Equitable Care in Direct Practice Medicine: AMA-MSS will ask the AMA to (1) investigate, with the American Academy of Private Physicians, the potential for direct practice medicine to serve as a cost saving tool for certain patients requiring 24-hour access to care; and (2) investigate, with American Academy of Private Physicians, the scope of direct practice medicine and study methods, including partnerships with academic facilities and tax subsidies, to improve the reach of direct practice medicine to include all classes. (MSS Res 27, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Improved Adequacy of Translation Services in Hospital and Pharmacy Settings: AMA-MSS will ask the AMA to amend policy H-215.982 by deletion and insertion as follows:

H-215.982 Translator Services in Hospitals

Our AMA encourages hospitals, health care institutions, including but not limited to hospitals and pharmacies, that serve populations with a significant number of non-English speaking patients to provide trained translator services.


Reduce Barriers to Preventive Health Care Delivery and Compensation: AMA-MSS will ask the AMA to support both the reduction of financial barriers to the delivery of cost-effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care. (MSS Res 20, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-12) (Modified: MSS GC Report A, I-16)

160.024MSS Transportation and Accessibility to Free Medical Clinics: AMA-MSS will ask the AMA to encourage initiatives that address transportation as a barrier to utilization of those institutions addressing the healthcare needs of the underserved in local communities. (Sub MSS Res 25, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 101, A-12) (Reaffirmed: MSS GC Report A, I-16)

160.025MSS Poverty Screening as a Clinical Tool for Improving Health Outcomes: AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (MSS Res 20, I-12) (Amended AMA Res 404, A-13 Adopted [H-160.909]) (Reaffirmed: MSS GC Report A, I-17)

160.026MSS Public Reporting of Physician Outcomes: AMA-MSS supports that all programs that publicly report physician outcomes consider a petition process that allows healthcare providers to request exceptions for extreme risk unaccounted for by risk adjustment, and procedures performed for palliative purposes. (MSS Res 13, A-13)

160.027MSS Readability of Patient Materials: AMA-MSS supports health literacy such that patient materials be written at a level understandable by the patient population. (MSS Res 16, A-13)

160.028MSS Improving Home Health Care: AMA-MSS will ask the AMA to support the establishment of state-based certification for home health care workers and regulatory oversight over home health agencies. (MSS Res 11, I-13) (AMA Res 703, A-14 Referred)

160.029MSS Protecting Medical Students’ Rights as Patients: That our AMA amend policy H-315.983 by insertion and deletion as follows:

H-315.983 Patient Privacy and Confidentiality

Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients’ privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients’ privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. (2) Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients’ medical history to governmental agencies or other entities,
beyond that which would be required by law. (3) Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. (4) Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. (5) The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. (6) Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. (7) Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. (8) When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. (9) Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. (10) Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. (11) Marketing and commercial uses of identifiable patients’ medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures (12) Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians’ control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. (13) Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. (14) Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. (15) In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should

(MSS Res 8, A-14) (AMA Res 2, I-14 Adopted [H-315.983])

160.030MSS Including Military History as Part of Standard History Taking: That our AMA (1) encourage the universal inclusion of military history in the standard history taking of all adults in civilian healthcare settings; and (2) support the addition of military history training to undergraduate, graduate, and continuing medical education and the continued refinement of existing screening resources. (MSS Res 17, A-14) (Reaffirmed Existing Policy in Lieu of AMA Res 306, A-15)

160.031MSS Concurrent Hospice and Life-Prolonging Care: AMA-MSS ask the AMA to amend policy H-85.955 by insertion and deletion as follows:

H-85.955 Hospice Care

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; and (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) seeks amendment of supports changes in the Medicare regulation law to eliminate the requirement that life-prolonging care be terminated before hospice will be reimbursed allow provision of concurrent curative and hospice care.

160.032MSS Feminine Hygiene Products: Our AMA-MSS supports the distribution of readily available feminine hygiene products in publicly funded institutions, including but not limited to schools, correctional facilities and shelters. (MSS Res 17, I-16)

160.033MSS Expanding Access to Screening Tools for Social Determinants of Health: AMA-MSS will ask that our AMA (1) provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; (2) support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and (3) support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. (MSS Res 03, I-16) (AMA Res 711, A-17 Referred)

160.034MSS Improving Language Access for Limited English Proficiency Patients: AMA-MSS supports initiatives to educate physicians and medical students on the appropriate use of medical interpreters. (MSS Res 32, I-16)

160.035MSS Implementation of Standardized HIPAA Training: Our AMA-MSS supports a standardized HIPAA training curriculum for medical professionals that is transferable between healthcare entities and defines an appropriate time interval for recertification. (MSS Res 45, I-16)

160.036MSS Improving Appropriate Language Access and Use of Interpreters in Healthcare Settings: AMA-MSS will ask that our AMA encourage the use of trained interpreters as a primary resource for patients with limited English proficiency, when available, in the stead of patient family members and friends. (MSS Res 06, A-17)

160.037MSS Mitigating the Transportation Barrier for Accessibility of Healthcare for the Medicaid Population: AMA-MSS (1) supports the research efforts to assess the utility and feasibility of state-funded support of Non-Emergency Medical Transportation programs and (2) supports the maintenance of funding for transportation services in state Medicaid programs. (MSS Res 21, A-18)

160.038MSS Supporting Life Narrative Services in Geriatric Patients: AMA-MSS supports the use of narrative services as a way to achieve holistic, compassionate geriatric patient care. (MSS Res 23 I-18)

160.039MSS Addressing Health Disparities Through Improved Transition of Care from Pediatric to Adult Care: AMA-MSS encourages the inclusion of pediatric to adult transition care training in the residency curricula with an emphasis on effective care for vulnerable patient populations such as ethnic and racial minorities. (MSS Res 18, A-19)

160.040MSS Supporting Research into the Use of Mobile Integrated Health Care and Community Paramedicine in Addressing the Primary Care Shortage: AMA-MSS will study mobile medical units as a means of delivering healthcare to underserved communities. (MSS Res 28, I-18)

160.041MSS Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill: AMA-MSS supports policies that promote accessibility of on-site physician home health care for the frail, chronically ill, and low-income populations. (MSS Res 45, A-18)

165.000MSS Health System Reform


165.007MSS Steps in Advancing towards Affordable Universal Access to Health Insurance: (1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports Expanding Health Insurance: The AMA Proposal for Reform; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (MSS Rep A, A-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13) (Modified: MSS Res 12, A-17)

165.009MSS Evaluation of the Principles of the Health Care Access Resolution: (1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16)

165.010MSS Development and Support of Prospective Personalized Health Planning: AMA-MSS will ask the AMA to: (1) continue to recognize the need for possible adaptation of the United States’ health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models, and measures that will assist
in creating a stronger focus on prospective care in the United States’ health care system; and (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing. (MSS Rep F, A-04) (AMA Res 422, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

165.011MSS Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits: AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public. (MSS Rep G, A-04) (AMA Amended Res 703, I-04 [H-290.982]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Report D, I-15) (Modified: MSS GC Report A, I-16)

165.012MSS Covering the Uninsured as AMA’s Top Priority: AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment. (MSS Res 10, I-05) (AMA Amended Res 613, A-06 Adopted [H-165.847]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Report D, I-15)

165.015MSS Maintaining Insurance Coverage and Empowering State Choice: AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act. (MSS Res 43, A-11) (Reaffirmed: MSS GC Report A, I-16)

165.017MSS MSS Support for State-by-State Universal Health Care: AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance. (MSS Res 13, I-14)

165.018MSS Study of Current Trends in Clinical Documentation: AMA-MSS will ask (1) that our AMA study how modern clinical documentation requirements, methodologies, systems, and standards have affected the quality and content of clinical documentation, and (2) that our AMA study current practices for clinical documentation training for physicians as well as in graduate and undergraduate medical education. (MSS Res 12, I-15) (AMA Res 702, A-16 Adopted as Amended)

165.019MSS Protecting Patient Access to Health Insurance and Affordable Care: AMA-MSS will ask that our AMA advocate that any health care reform legislation considered by Congress ensures continued improvement in patient access to care and patient health insurance coverage by maintaining: (a) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (b) Income-dependent tax credits to subsidize private health insurance for eligible patients, (c) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (d) Maintaining dependents on family insurance plans until the age of 26, (e) Coverage for preventive health services, (f) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (g) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (MSS Late Res 01, I-16 Immediate Transmittal AMA Res 224, Substitute Resolution Adopted In lieu of Res 205, 209, 224, and 226 [D-165.935])

165.020MSS National Healthcare Finance Reform: Single Payer Solution: (1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate
federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS. (MSS Res 12, A-17)

165.021MSS Encourage the Final Evaluation Reports of Section 115 Demonstrations at the End of the Demonstration Cycle: AMA-MSS will ask the AMA to encourage the Centers for Medicare and Medicaid Services to establish written procedures that require finale evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status. (MSS Res 20, A-18)

165.022MSS Expanding AMA’s Position on Healthcare Reform Options: AMA-MSS will ask the AMA to (1) rescind HOD policy H-165.844; (2) rescind HOD policy H-165.985; (3) amend by deletion HOD policy H-165.888 as follows:

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
   a. Physicians maintain primary ethical responsibility to advocate for their patients’ interests and needs.
   b. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
   c. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
   d. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan’s policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
   e. And national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
   f. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce and adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
   g. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
   h. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislations.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorder and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients; and

(4) amend by deletion HOD policy 165.838 as follows:

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: (a) Health insurance coverage for all Americans; (b) Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; (c) Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; (d) Investments and incentives for quality improvement and prevention and wellness initiatives; (e) Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care; (f) Implementation of medical liability reforms to reduce the cost of defensive medicine; (g) Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange by self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: (a) Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services; (b) Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system; (c) Medicare payment cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is
properly attributed and risk-adjusted; (d) Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate; (e) Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; (f) arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government run health care system is not in the best interest of the country and must not be a part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.


170.000MSS Health Education

170.001MSS Prevention & Health Education: AMA-MSS supports the following principles: (1) Health education should be a required part of primary and secondary education; (2) Private industry should be encouraged to provide preventive services and health education to employees; (3) All health care professions should be utilized for the delivery of preventive medicine services and health education; (4) Greater emphasis on preventive medicine should be incorporated into the curriculum of all health care professionals; (5) A sufficient number of training programs in preventive medicine and associated fields should be established, and adequate funding should be provided by government if private sources are not forthcoming; (6) Financing of medical care should be changed to include payment for preventive services and health education; (7) Appropriate legislation should be passed to protect the health of the population from behavioral and environmental risk factors, including, but not limited to, the following: (a) handgun control, (b) antismoking, (c) enforcement of drunk driving laws, (d) mandatory use of seat belts, (e) environmental protection laws, (f) occupational safety, and (g) toxic waste disposal; and (8) Preventive health services should be made available to all population segments, especially those at high risk. (MSS Rep C, I-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep C, A-04) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


170.003MSS Incorporation of Adoption into Public School Health Education Curriculum: AMA-MSS will ask the AMA to support the incorporation of information on adoption into public school sex education or family planning curricula. (AMA Amended Res 4, I-90 Adopted) (Reaffirmed: MSS Rep B,
170.004MSS  **Health Education:** AMA-MSS will ask the AMA to urge all state medical societies to urge their respective state departments of education to implement model health education curricula, act as clearinghouses for data on curriculum development, work with local school districts to implement health education programs and seek funding for these programs. These health education programs should contain provisions for educator training and development of local community health advisory committees. (AMA Sub Res 417, I-91 Adopted [H-170.980]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

170.005MSS  **Teaching Sexual Restraint to Adolescents:** AMA-MSS will ask the AMA to: (1) support efforts in the mass media, schools, and communities to make abstinent sexual behavior more socially acceptable and to help students develop the skills and self-confidence they need to restrict their sexual behavior; and this support will include efforts to increase funding and policies at the local, state and federal levels, though not necessarily at the expense of existing policies; and (2) encourage school districts to adopt sex education curricula that have a proven record of reducing teenage sexual activity. (AMA Amended Res 407, A-94 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

170.007MSS  **Teaching Preventive Self Examinations to High School Students:** AMA-MSS will ask the AMA to support the development of programs to teach self-breast examinations to female high school students and testicular self-examinations to male high school students and encourage county medical societies to assist local high schools in implementing such programs. (MSS Sub Res 17, I-96) (AMA Sub Res 406, A-97 Adopted [H-170.969]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Rep A, I-16)

170.008MSS  **Increasing HPV Education:** AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education. (MSS Sub Res 37, I-98) (Reaffirmed Existing Policy in Lieu of AMA Res 405, A-99) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

170.009MSS  **Teaching Sexual Education to Disabled Youth in School:** AMA-MSS will ask the AMA to encourage the Department of Education to ensure mentally and/or physically disabled youth receive more effective and comprehensive sexual education and encourage the Department of Education to offer sexual education counseling targeted to mentally and/or physically disabled youth. (MSS Res 22, I-04) (AMA Amended Res 406, A-05 Adopted [D-170.996]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

170.010MSS  **Abstinence-Only Education and Federally-Funded Community-Based Initiatives:** AMA-MSS supports initiatives to: (1) extend AMA support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in H-170.968; (2) oppose federal funding of community-based abstinence-only sex education programs and instead support federal funding of comprehensive sex education programs that teach about contraceptive choices and safe sex while also stressing the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections; and (3) support school education programs that include recognizing and preventing sexual abuse and dating violence. (MSS Res 23, I-04) (AMA Amended Res 834 Adopted [H-170.968]) (Amended: MSS Late Res 1, A-12) (Reaffirmed: MSS GC Report A, I-17)

170.011MSS  **Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula:** AMA-MSS will ask the AMA to strongly urge existing school health education programs to emphasize the high

170.012MSS Nutrition Education for Parents of School Aged Children: AMA-MSS encourages the development of informational nutrition programs to be implemented through the public school system and methods, such as public service announcements or community awareness campaigns, with the goal to educate parents about healthy lifestyles in an effort to prevent and reduce the prevalence of overweight and obesity in children and adolescents. (MSS Res 7, A-06) (Reaffirmed: MSS Res 46, I-10) (Reaffirmed: MSS GC Rep D, I-15)

170.013MSS Public School Screening for Childhood Obesity: AMA-MSS will ask the AMA to (1) encourage research and evaluative studies to develop a unified, evidence-based tool to accurately determine youth and adolescent weight status; and (2) encourage wide-scale, comprehensive, school-based obesity prevention that includes didactic curriculum, nutrition standards, physical education programs, and parent and teacher involvement. (MSS GC Report E, A-07) (AMA Policy Reaffirmed in Lieu of AMA Res 803) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)


170.015MSS Reducing the Risk of Sexually Transmitted Infections in Patients Age 50 and Older: AMA-MSS will ask the AMA to encourage physicians to educate their patients, particularly those of age 50 and older, on safe-sex practices and on the risk of sexually transmitted infections. (MSS Amended Res 16, A-09) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 510, A-10) (Reaffirmed: MSS GC Rep A, I-14)

170.016MSS Sexual Violence Education and Prevention in High Schools with Sexual Health Curricula: AMA-MSS will ask that our AMA amend policy H-170.968 by insertion and deletion as follows:

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

Our AMA:(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, consent communication to prevent dating violence and reduce substance use while promoting healthy relationships, and school-based
condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people, and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; and (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on health relationships, sexual health, conversations about consent and substance abuse. (CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09) (MSS Res 24, I-15) (AMA Res 405, A-16 Adopted as Amended with Change in Title to “Sexual Violence Education and Prevention in Schools” [ ])

170.017MSS  **Stem Cell Tourism:** AMA-MSS will ask (1) that our AMA study best practices for physicians to advise patients seeking to engage in stem cell tourism and how to guide them in risk assessment, and (2) that our AMA encourage further research on stem cell tourism, and urge physicians to educate themselves on these issues. (MSS Res 28, I-15)

170.018MSS  **Improving Safety and Health Code Compliance in School Facilities:** AMA-MSS will ask our AMA to (1) support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections; (2) support policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods; and (3) support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure. (MSS Res 09-I-17)

170.019MSS  **Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula:** (1) AMA-MSS encourages school health education programs to emphasize not only HPV association with cervical cancer and genital warts, but also penile, vaginal, vulvar, oropharyngeal, and anal cancers; and (2) AMA-MSS encourages HPV and HPV vaccination school education be more targeted to students at the recommended age of vaccination. (MSS Res 04, A-18)

170.020MSS  **Sex Education Materials for Students with Limited English Proficiency:** Our AMA-MSS will ask our AMA to amend policy H-170.968 by insertion as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts
adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternative in birth control, and other issues aimed prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (g) are part of an overall health education program; (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;

(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;

(7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and

(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;

(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health and conversations about consent;

(10) Encourages physicians and all interested parties to develop best-practice, evidence-based guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate.

(MSS Res 23, I-17) (AMA Res 414/428 A-18, Appended [H-170.968])

180.000MSS  Health Insurance

180.001MSS  Consumer Choice Principles: AMA-MSS supports the following AMA principles for any consumer choice health plan that might be adopted, as contained in AMA Board of Trustees Rep C (I-82): (1) Multiple Choice of Plans - Insurance Coverage options should be available to employees;
accordingly employers, through tax incentives, should be encouraged (but not required) to offer health benefit plans and, if they choose to offer coverage, to offer employees a choice from among multiple options. (2) **Minimum Benefits** - Health insurance plans offered employees should contain required minimum benefits, including catastrophic coverage. (3) **Equal Contributions** - Equal employer contributions should be made for health benefit plans, regardless of the plan selected by the employee. (4) **Non-Taxable Rebate to Employees** - Employees should receive a non-taxable rebate where an employee chooses a plan option costing less than the amount of the employer contribution. (5) **Maximum Contribution Limitation** - A limit (adjustable for inflation) should be placed on the amount of health insurance premiums paid by an employer for tax deduction by the employer as a business expense. Amounts paid in excess of this limit would be taxable income to the employee. (6) **Employer Non-Compliance** - Unqualified plans should not be eligible for tax deduction. (MSS Rep C, I-82, Attachment 2) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**180.002MSS**  

**180.003MSS**  

**180.004MSS**  

**180.008MSS**  
**Insurance For Domestic Partners**: AMA-MSS will ask the AMA to encourage state medical societies to seek legislation in their states that would assure the eligibility of health care benefits for same sex and opposite sex partners and their children consistent with the eligibility of spouses of married employees/students and the children of these spouses. (AMA Res 214, I-94 Not Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**180.010MSS**  
**Parity in Health Care for Domestic Partnerships**: AMA-MSS will ask the AMA to: (1) encourage the development of domestic partner health care benefits in the public and private sector; (2) support parity of pre-tax health care benefits for domestic partnerships; and (3) support legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision-maker in the Uniform Probate Code in the absence of an alternative health care proxy designee. (MSS Sub Res 6, A-01) (AMA Amended Res 101, I-01 Adopted [H-140.901, H-185.958]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)

**180.012MSS**  
**Expanding Post-Mastectomy Options for Cancer Survivors**: AMA-MSS will ask the AMA to recommend that third party payors provide coverage and reimbursement for medically beneficial breast cancer treatments including but not limited to prophylactic contralateral mastectomy. (MSS Res 11, A-02) (AMA Amended Res107, A-03 Adopted [H-55.978]) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

**180.013MSS**  
**Value Based Insurance Design**: AMA-MSS will ask the AMA to recommend to the AMA

180.014MSS  Antitrust Exemption for Health Insurance Companies: AMA-MSS will ask the AMA to urge federal authorities to oppose antitrust exemption status for health insurance companies. (MSS Res 22, A-12) (Reaffirmed: MSS GC Report A, I-17)

180.015MSS  Privacy Issues for Minors Regarding Insurance Company Explanations of Benefits: AMA-MSS will ask the AMA to (1) advocate for maintaining privacy regarding the doctor patient relationship for adults and dependents who are insured through their spouse, parent, or guardian, respectively; (2) advocate against allowing insurance companies to send Explanations of Benefits containing sensitive medical information regarding both adults and dependents to anyone other than the patient or their health care provider; and (3) advocate that Explanations of Benefits be made available only if an insurance claim has been denied, in which case the information should be sent directly to the (adult or dependent) patient, who may then choose to discuss it with their physician or share it with their spouse, parent, or guardian. (MSS Res 11, A-13) (AMA Res 801, I-13 Referred)

180.016MSS  Emergency Department Insurance Linking: That our AMA support the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing emergency medical services. (MSS Res 32, A-14) (AMA Res 803, I-14 Adopted [H-185.934])

180.017MSS  Increasing Access to Medical Devices for Insulin-Dependent Diabetics: AMA-MSS will ask that our AMA work with relevant stakeholders to encourage the development of plans for inclusion in the Medicare Advantage Value Based Insurance Design Model that reduce copayments/coinsurance for diabetes prevention, medication, supplies, and equipment including pumps and continuous glucose monitors, while adhering to the principles established in H-185.939. (MSS Res 04, A-16)


200.000MSS  Health Workforce


200.003MSS  AMA Opposition to Primary Care Quotas: AMA-MSS will ask the AMA to: (1) strongly oppose primary care quota systems; (2) oppose efforts by federal and state governments that would arbitrarily further control specialties for which medical students may qualify; and (3) continue to support and promote the identification of and funding for incentives to increase the number of primary care physicians. (AMA Sub Res 306, I-92 Adopted in Lieu of Res 325, I-92) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

200.006MSS  National Physician Workforce Planning: AMA-MSS will ask the AMA to support the concept that the Council on Graduate Medical Education and/or any equivalent national workforce planning body should be solely advisory in nature and be appointed in a manner that ensures bipartisan representation, including adequate physician representation. (AMA Res 320, I-93 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


200.010MSS  Primary Care Internships: AMA-MSS will ask the AMA to encourage state medical societies, in conjunction with primary care specialty societies, to promote and encourage primary care internship and/or preceptorship programs for medical students in their states as a positive means toward increasing the number of primary care physicians. (MSS Sub Res 307, I-94 Adopted [H-200.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

200.012MSS  Availability of Information on Physician Workforce Needs for Residency Applicants: AMA-MSS will ask the AMA to support measures to increase the availability of information on specialty choice to medical students by gathering and disseminating information on market demand and health manpower needs for the medical and surgical specialties. (AMA Amended Res 314, A-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


200.015MSS  Supporting the Expansion of U.S. Residency Programs: AMA-MSS supports increases in the number of residency positions according to AMA workforce studies, where such increases would not undermine existing physician residency positions in any of the states. (MSS Amended Sub Res 1, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

200.016MSS  Increasing Medical School Class Sizes: AMA-MSS will ask the AMA to support increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (MSS Sub Res 14, I-07) (AMA Res 309, A-08 Adopted [D-295.938]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

200.017MSS  Medical Student Representation in National Health Service Corps Planning: AMA-MSS will advocate to increase medical student representation in the decision-making process of the National Health Service Corps during the implementation of the Patient Protection and Affordable Care Act. (MSS Res 47, I-10) (Reaffirmed: MSS GC Rep D, I-15)

200.018MSS  Incorporating Community Health Workers into the U.S. Health Care System: That our AMA (1) encourages the incorporation of community health workers into the U.S. health care system and support legislation that integrates community health workers into care delivery models especially in communities of economically disadvantaged, rural, and minority populations; and (2) supports appropriate stakeholders to define community health workers in order to define their required level of training and scope of practice and to legitimize their role as health care providers. (MSS Res 4, A-14) (AMA Res 805, I-14 Referred)
200.019MSS Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems: Our AMA-MSS will ask (1) That our AMA support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to qualified genetics specialists; (2), That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results; and (3) That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. (MSS Res 11, A-16).

200.020MSS Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers: AMA-MSS will ask the AMA to (1) urge the Department of Defense to immediately and publicly release the required assessments that the Military Departments, the Joint Staff, and organizations within the Office of the Secretary of Defense reportedly conducted and submitted in writing by the US Army Surgeon General in Congressional testimony to Senate Appropriations Committee regarding the operational medical requirements needed to support the National Defense Strategy that the Military Departments used in planning to reduce overall uniformed medical positions, as well as provide immediate clarification regarding the proposed cuts including the number of medical provider billet cuts and their distribution amongst specialties and services; and (2) That if no such Department of Defense assessments exist, are immediately released, or appear inadequate to the AMA to justify the proposed cuts to military billets, that the AMA will urgently lobby the US Congress to implement legislation mandating a study in the next National Defense Authorization Act to assess the impact of potential cuts on cost and healthcare quality outcomes for military service members, dependents, and retirees before drastic cuts are executed; and (3) strongly oppose any reductions to military GME residency or fellowship positions without dedicated congressional funding for parity civilian residency positions in addition to any other planned increases to civilian GME to avoid further exacerbating the United States’ physician shortage. (MSS Late Resolution 01, A-19, Immediate Forward to HOD, Amended and Adopted by HOD, AMA Res 246 A-19 [H-40.995])

215.000MSS Hospitals

215.001MSS Hospital Dress Codes for the Reduction of Nosocomial Transmission of Disease: AMA-MSS will ask the AMA to advocate for the adoption of hospital guidelines for dress codes that minimize transmission of nosocomial infections, particularly in critical and intensive care units. (MSS Amended Res 6, I-08) (AMA Res 720, A-09 Referred) (Reaffirmed: GC Rep B, I-13)

215.002MSS Studying Hospital-Enforced Admissions, Testing, and Procedure Quotas: AMA-MSS will ask the AMA to study the extent to which U.S. hospitals inappropriately interfere in physicians’ independent exercise of medical judgment, including but not limited to the use of admissions, testing, and procedure quotas. (MSS Res 19, I-13)

215.003MSS Preventive Screening and Treatment of Malnutrition in Hospital Patients: AMA-MSS will ask the AMA to (1) support the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals; (2) support the establishment of national registries for the sharing of information on prevalence of malnutrition, health outcomes, costs, and other metrics associated with the performance of nutrition support teams and other preventive nutritional interventions; and (3) support the reimbursement of assessment and interventions provided by nutrition support teams as preventive services where they are used to preclude or mitigate adverse health outcomes, rather than manage disease-related malnutrition. (MSS Res 29, I-13)
215.004MSS  Banning the Sale of Sugar-Sweetened Beverages in Hospitals: AMA-MSS supports measures that restrict retail or vending machine sales of sugar-sweetened beverages in hospitals, clinics, or food service outlets that operate in space owned by licensed health care facilities. (MSS Res 9, I-15)

215.005MSS  Prevention of Newborn Falls in Hospitals: Our AMA-MSS will ask that our AMA support implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches. (MSS Res 25, A-16)

215.006MSS  Amendment to H-150.949 Healthy Food Options in Hospitals: AMA-MSS will ask the AMA to encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, Health Food Options in Hospitals to read:

Health Food Options in Hospitals Medical Care Facilities H-150.949

(1) Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on the premises of hospitals Medical Care Facilities.

(2) Our AMA hereby calls on all hospitals Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.

(3) Our AMA hereby calls for hospital Medical Care Facility cafeterias and inpatient meal menus to publish nutritional information.

(MSS Res 26, A-19)

245.000MSS  Infant Health


245.002MSS  AMA Support for Breastfeeding: AMA-MSS will ask the AMA to encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options. (AMA Amended Res 506, A-93 Adopted [H-245.982]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

245.003MSS  Sudden Infant Death Syndrome: AMA-MSS will ask the AMA to encourage the education of parents, physicians, and all other health care professionals involved in newborn care regarding methods to eliminate known SIDS risk factors, such as prone sleeping, soft bedding, and parental smoking. (AMA Res 414, A-95 Adopted [H-245.977]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

245.006MSS  Detection, Diagnosis and Intervention of Hearing Loss in Newborns and Infants: AMA-MSS will ask the AMA to support the establishment of statewide programs for the early detection and diagnosis of hearing loss as well as interventional programs for all affected newborns and infants.
245.010MSS Safe Haven for Newborns: AMA-MSS supports efforts to lower barriers to adoption including the coordination of anonymous adoption and supports state efforts to decrease the number of abandoned infants by supporting legislation that would protect mothers from prosecution who anonymously deliver their infant safely to a licensed health care facility, thus enabling the facility to initiate the adoption process. (MSS Sub Res 5, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

245.011MSS Protecting a Mother’s Right to Breastfeed: AMA-MSS supports state legislation that clarifies and enforces a mother’s right to breastfeed in a public place and will encourage all states to adopt breastfeeding legislation which clarifies and protects a mother’s right to breastfeed in a public place. (MSS Res 15, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

245.012MSS Continuing the Fight to Lower Infant Mortality in the United States: AMA-MSS supports the reduction of the rate of infant mortality in the United States through the promotion of access to prenatal and infant care, education on healthy choices to reduce risks, and research on how to best reduce infant mortality. AMA-MSS will communicate to the AMA Health Disparities Initiative the importance of reducing infant mortality in the United States, and specifically where this problem manifests as racial or ethnic disparities in health indicators. (MSS Res 26, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13)

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

245.014MSS National Minimum Newborn Screening Recommendations: AMA-MSS will ask the AMA to: (1) support and recognize a need for uniform minimum newborn screening (NBS) recommendations; (2) encourage continued research on the benefits of NBS for certain diseases and the development of new NBS technology; and (3) recommend the adoption of a national minimum uniform screening panel for newborns by establishment of model state legislation and encouragement of legislation for adoption by Congress, pending completion and a review of the evaluation by the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children. (MSS Sub Res 27, I-04) (AMA Res 530, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)


245.016MSS Doctors Defending Breastfeeding: AMA-MSS will ask the AMA to: (1) Discourage hospitals and health care professionals from distributing formula and bottles to women who are willing and able to breastfeed; (2) Oppose the marketing or distribution of infant formula in ways that may interfere with the protection and promotion of breastfeeding; and (3) Recognize the inherent conflict of interest present when infant formula manufacturers provide financial support for research into or

245.017MSS Early Hearing Detection and Intervention: AMA-MSS will ask the AMA to (1) support Early Hearing Detection and Intervention (EHDI) to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and (2) support federal legislation to provide appropriate resources, coordination, and education for EHDI follow-up with infants who fail initial hearing screening tests. (MSS Res 29, I-10) (AMA Res 514, A-11 Adopted as Amended [H-245.970]) (Reaffirmed: MSS GC Rep D, I-15)

245.018MSS Revision of Resuscitation Policies for Premature Infants Born at the Cusp of Viability: AMA-MSS supports programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (MSS Sub Res 9, A-12) (Reaffirmed: MSS GC Report A, I-17)

245.019MSS Support for Medicaid Reimbursement of Neonatal Male Circumcision: AMA-MSS will ask the AMA to (1) encourage state Medicaid reimbursement of neonatal male circumcision; and (2) update current policy to support the general principles of the revised 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads “Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV.” (MSS Res 30, I-12) (AMA Res 503, A-13 Adopted [H-60.945]) (Reaffirmed: MSS GC Report A, I-17)

245.020MSS Supporting Autonomy for Patients with Differences of Sex Development: AMA-MSS will ask that our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making. (MSS Res 17, I-15) (AMA Res 003, A-16 Referred)

245.021MSS The Diaper Gap: AMA-MSS will ask that our AMA support increased access to affordable diapers. (MSS Res 05, A-17)

245.022MSS Support for Rooming-In of Neonatal Abstinence Syndrome Patients with their Parents: AMA-MSS will ask the AMA to (1) support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient’s health and safety permits, and as supported by validated risk stratification tools for rooming-in programs; and (2) support the education of physicians about rooming-in patients with neonatal abstinence syndrome. (MSS Res 01, I-18) (AMA Res 525, A-19, Adopted as amended [H-420.949])

250.000MSS International Health

250.001MSS Medical Care in Countries in Turmoil: AMA-MSS will ask the AMA to: (1) support provision of food, medicine, and medical equipment to civilians threatened by natural disaster or military conflict within their country; (2) express concern about the disappearance of physicians, medical students, and health care professionals and withholding of medical care to the injured in such countries in turmoil; and (3) ask appropriate international health organizations to monitor the status of health care in these countries. (AMA Amended Res 133, A-83 Adopted [H-65.994]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
250.010MSS  **Medical Supply Donations to Foreign Countries:** AMA-MSS will ask the AMA to encourage the continuing donation of medical equipment, drugs, computers, textbooks, and any other unused medical supplies. (1) AMA-MSS encourages chapters to collect medical supplies from their local physicians, hospitals, clinics, etc. (MSS Amended Res 61, I-98) (AMA Res 608, A-99, Referred for decision) (BOT Adopted AMA Res 608, A-99 [D-250.992]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

250.011MSS  **Low Cost Drugs to Poor Countries During Times of Pandemic Health Crisis:** AMA-MSS will ask the AMA to: (1) support increased availability of anti-retroviral drugs and drugs to prevent active TB infection to countries where HIV/AIDS is pandemic; (2) encourage pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (3) work with the World Health Organization, UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability. (MSS Amended Res 12, I-01) (AMA Res 402, A-02 Adopted [H-250.988]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)

250.013MSS  **Support of Medical and Surgical Supply Recycling Programs:** AMA-MSS promotes organizations that provide medical and surgical supplies to underserved areas through recycling programs and encourages AMA-MSS chapters to participate in medical and surgical supply recycling programs. (MSS Res 24, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

250.017MSS  **Medical Tourism:** AMA-MSS supports informing patients about potential risks and benefits of going abroad to receive medical treatment. (MSS Resolution 1, A-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

250.018MSS  **Essential Medicines for the Developing World:** AMA-MSS will ask the AMA to (1) support universities engaging nontraditional partners in order to create new opportunities for neglected disease drug development, including public-private partnerships, grant-making organizations, nonprofits, and developing-world research institutions; and (2) support the protection of fair access to essential medicines in developing countries. (Sub MSS Res 4, I-07) (AMA Res 515, A-08 Adopted [H-100.963]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

250.019MSS  **Global HIV/AIDS Prevention:** AMA-MSS will ask the AMA to (1) support continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution; and (2) extend its support of comprehensive family-life education to foreign aid programs, promoting abstinence while also discussing the role of safe sexual practices in disease prevention. (MSS Late Res 3, A-08) (AMA Res 438, A-08 Withdrawn) (Reaffirmed: GC Rep B, I-13)

250.020MSS  **Refugee Health Care:** AMA-MSS will ask the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. (MSS Amended Res 4, A-09) (AMA Res 804, I-09 [H-350.957]) (Modified and Reaffirmed: MSS GC Rep A, I-14) (Reaffirmed: MSS Res 30, A-18)

250.022MSS  **Foreign Emergency Medical Relief Policy and Procedures for Hospitals:** AMA-MSS will ask the AMA to encourage the American Hospital Association to develop policies and procedures to facilitate the coordination of logistics in the event of an international disaster requiring urgent emergency medical relief. (MSS Res 36, I-10) (Reaffirmed: MSS GC Rep D, I-15)

250.023MSS  **Increasing Access to Care in Resource Limited Settings Using the President's Emergency Plan for AIDS Relief:** AMA-MSS (1) supports the efforts of the Global Health Service Partnership to
strengthen African healthcare workforces; and (2) recognizes the benefits of including loan repayment in the Global Health Service Partnership funded from a variety of sources. (MSS GC Rep E, A-12) (Reaffirmed: MSS GC Report A, I-17)

250.024MSS Regulations in Times of Armed Conflict: AMA-MSS will ask the AMA to (1) endorse the World Medical Association’s “Regulation in Times of Armed Conflict” as policy on the topic of medical neutrality; and (2) advocate that the United States use its voice in international affairs to protect medical neutrality. (MSS Res 22, A-13) (AMA Policy H-520.998 Reaffirmed in Lieu of AMA Res 601, I-13)

250.025MSS Voluntary Reporting of Complications from Medical Tourism: AMA-MSS will ask that our AMA ask the appropriate organizations to maintain a de-identified database for the voluntary reporting of outcomes resulting from medical procedures performed abroad. (MSS Res 20, I-15) (AMA Res 703, A-16 Adopted as Amended)

250.026MSS Research and Monitoring to Ensure Ethics of Global Health Programs: AMA-MSS will ask that our AMA amend Policy H-250.993 by insertion and deletion as follows:

H-250.993 Overseas Medical Education Developed by US Medical Associations

The AMA will: (1) continue to focus its international activities on and through organizations that are multinational in scope; (2) encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world; (3) encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world; (4) work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities; (5) work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods; and (6) communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLO™), to increase student participation in international electives. (CME Rep. 6, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: CME Rep. 9, A-12)


250.027MSS Emphasizing Training in the Treatment of Refugees: AMA-MSS supports medical student collaboration with appropriate entities for training in the provision of refugee medical care. (MSS Res 08, I-16)

250.028MSS Increasing Access to Healthcare Insurance for Refugees: AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees, and (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans. (MSS Res 05, I-16, First Resolve adopted, Second Resolve Referred) (AMA Res 006, A-17 Adopted [H-350.956]) (Reaffirmed: MSS CGPH Rep A, I-17, second resolve clause added)

250.029MSS Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services: AMA-MSS will ask the AMA to (1) upon the release of any proposed rule or regulations that would deter immigrants and/or their dependents from utilizing non-cash public benefits including Medicaid,
CHIP, WIC, and SNAP, issue a formal comment expressing its opposition; and (2) amend AMA policy H-20.901 by addition and deletion to read as follows:

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

(MSS Res 01, A-18) (AMA Res. 254, A-18, Adopted [D-440.927])

250.030MSS Opposing the Office of Refugee Resettlement’s Use of Medical Psychiatric Records for Evidence in Immigration Court: AMA-MSS will ask the AMA to (1) advocate that healthcare services provided to minors in immigrant detention focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent (MSS Res 15, I-18) (AMA Res 013, A-19, Adopted [H-65.958])

255.000MSS International Medical Graduates

255.001MSS The Status of Foreign Medical School Graduates in the United States: AMA-MSS supports the following principles: (1) The US Government should provide preferential support (e.g., financial aid) to US citizens enrolled in US medical schools, as opposed to alien and US FMG's. (2) There should be guidelines to limit the number of FMG's entering the US for the purpose of graduate medical training as well as to practice medicine modified as appropriate in response to assessment of needs. Public policy toward extending the rights of foreign-trained physicians to practice in the US should be sensitive to the impact of the individual's practice on the health care delivery system. (3) Immigration legislation should allow adequate time to complete training. (4) Steps should be taken to aid developing countries in providing incentives for their physicians to return to or remain in their own country. (5) Determination of an individual’s qualifications should include assessment of the individual student or medical school graduate as well as the foreign medical school attended. (6) Individuals contemplating a career in medicine should be informed of the requirements necessary to successfully enter the US medical profession as well as residency training programs' preference for graduates of US medical schools. (MSS Position Paper 1, A-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


255.003MSS Licensure of International Medical Graduates: AMA-MSS supports equivalent licensing requirements for all physicians seeking licensure in the US, and opposes the development of separate licensing criteria, including exams, for any group. (MSS Rep D, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
255.004MSS United Nations Population Fund: AMA-MSS will ask the AMA to: (1) support reinstitution of U.S. funding to the United Nations Fund for Population Activities or other United Nations population and reproductive health programs consistent with AMA policy; and (2) educate its members about the possible consequences of the withdrawal of U.S. funding from the United Nations Fund for Population Activities and its support for the reinstitution of such funding. (MSS Res B, I-03) (AMA Res 441, A-04 Adopted [D-250.994]) (Reaffirmed: MSS Res E, I-08) (Modified: GC Rep B, I-13) (D-250.994 Rescinded: CSAPH Rep 1, A-14)

255.006MSS Support Equal Standards for Foreign Medical Schools Seeking Title IV Funding: AMA-MSS will ask that our AMA support the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (MSS Res 30, I-16) (AMA Res 304, A-17 Adopted [appended to H-255.988])

270.000MSS Legislation and Regulation

270.001MSS Support of Legislation Affecting Medical Students: AMA-MSS will ask the AMA to establish guidelines so that state societies would, when considering legislation affecting medical students, solicit input from medical school student governments, consider student views, and inform the medical student governments of decisions on these issues. (AMA Amended Res 163, A-79 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


270.004MSS Policy on the "Gag Rule": AMA-MSS will ask the AMA to actively work with Congress and other involved organizations to oppose any legislation and/or regulation that would interfere with a physician's ability to provide information about all treatment options available to his or her patients, and/or that would interfere with the privacy of the physician-patient relationship. (AMA Sub Res 213, A-91 Adopted in Lieu of AMA Res 254, A-91) (Reaffirmed: MSS Res B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


270.009MSS Protection for Physicians who Prescribe Pain Medication: AMA-MSS will ask the AMA to: (1) support the idea that physicians who prescribe pain medication to relieve chronic pain of both malignant and non-malignant origins should be freed from the burden of excessive regulatory scrutiny and censure; and (2) seek to implement legislation protecting physicians who treat chronic pain of malignant and non-malignant origins. (MSS Amended Sub Res 11, I-96) (AMA Res 209, A-97, Referred) (BOT Rep 1, I-97 Adopted [H-120.960]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)


270.012MSS Opposing Legislation of Medical Procedures: AMA-MSS strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient. (MSS Amended Sub Late Res 1, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)


270.016MSS Hate Crimes: AMA-MSS will ask the AMA to recognize that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States. (MSS Amended Late Res 8, I-98) (AMA Amended Sub Res 228, I-98 Adopted [H-65.980]) (Reaffirmed: MSS Res E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

270.017MSS Support for Legislation for Businesses to Provide Breastfeeding Employees Time, Facilities and Equipment for Breastfeeding: AMA-MSS will ask the AMA to support legislation encouraging and promoting breast feeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises. (MSS Sub Res 12, A-01) (AMA Res 243, A-01 Not Adopted) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

270.019MSS Implementation of Automated External Defibrillators in High School and College Sports Programs: AMA-MSS will ask the AMA to (1) support state legislation and/or state educational policies encouraging each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator (AED) and trained personnel on its premises; and (2) support state legislation and/or state educational policies encouraging athletic coaches, sports medicine personnel, and student athletes to be trained and certified in CPR, AED, basic life support, and recognizing the signs of sudden cardiac arrest. (MSS Sub Res 5, I-07) (AMA Res 421, A-08 Adopted [D-470.992]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

270.020MSS Professional Promotion Disclosure Registry: AMA-MSS supports initiatives to create an enforced, transparent, and publicly accessible national registry that would document and itemize individual gifts and payments to physicians from the pharmaceutical, device, and biologic industries; and (2) supports the development of specifications outlining criteria that should be included in any professional promotion disclosure registry in terms of enforcement, transparency, public availability, and reported payments (in accordance with AMA ethical guidelines depicting appropriate payments) to optimize and unify various professional promotion monitoring systems

270.021MSS National Cosmetics Registry and Regulation: AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all cosmetics and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall cosmetic products determined to be harmful based on the FDA’s product recall classifications. (MSS Amended Res 11, A-09) (Reaffirmed: MSS GC Rep A, I-14)

270.022MSS Promoting Transparency to Stimulate Improved Quality: AMA-MSS will ask the AMA to encourage development of public and hospital-based reporting systems that create transparency into individual physician performance to stimulate quality improvement and better-informed patient and physician decision-making. (MSS Res 13, A-10) (AMA Policies Reaffirmed in Lieu of AMA Res 808, I-10) (Reaffirmed, MSS GC Rep D, I-15)

270.023MSS Requiring Placement of Automated External Defibrillators in All Nursing Homes: AMA-MSS will ask the AMA to support state legislation that mandates Automated External Defibrillator placement in all nursing homes as a condition of licensure. (MSS Res 28, A-11) (Reaffirmed Existing Policy in Lieu of AMA Res 208, I-11) (Reaffirmed: MSS GC Report A, I-16)

270.024MSS Addressing Safety and Regulation in Medical Spas: AMA-MSS will ask the AMA to (1) advocate for state regulation over medical spas to include a classification system of traditional salon treatments and medical procedures, with recommendations as to who may perform procedures based on the level of risk to the patient and requirements for practitioners to be licensed by an appropriate Board of Registration; (2) advocate that botulinum toxin injections be considered the practice of medicine; and (3) take steps to increase the public awareness about the dangers of medical spas by encouraging the creation of formal complaint procedures and accountability measures within the Department of Health and Human Services in order to increase transparency. (MSS Res 38, A-11) (AMA Res 209, I-11 Adopted as Amended) (Reaffirmed: MSS GC Report A, I-16)

270.025MSS Protecting the Patient and Physician Relationship from Legislative Regulation: AMA-MSS (1) opposes legislation that requires physicians to perform medical procedures without valid medical indication or contrary to standards of care, especially as it concerns mandates to perform fetal ultrasounds on patients; and (2) opposes legislation that mandates specific counseling by physicians to patients, including mandatory viewing and description of fetal ultrasound images or required listening of fetal heart sounds. (MSS Res 10, A-12) (Reaffirmed: MSS GC Report A, I-17)

270.026MSS Strongly Advocate for Federal Funding for Indian Health Services: AMA-MSS (1) supports increased federal funding for Indian Health Service programs that directly influence medical student education opportunities; (2) supports AMA advocacy that all of the facilities that serve American Indian and Alaska Native populations under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers; and (3) supports the AMA partnering with recognized American Indian health advocacy organizations like the National Indian Health Board, the National Congress of American Indians, and the Association of American Indian Physicians to advocate for increased funding for Indian Health Services in Congress. (MSS Res 27, A-13)

Opposition to Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs: Our AMA-MSS will as the AMA to amend policy H-270.966 by insertion and deletion as follows:

H-270.966 Disclosure of Drug Use and Addiction Treatment History in Public Housing Assistance Programs

270.028MSS
The AMA opposes: a) Section 301 d (the Grams Amendment of the Public Housing Reform and Responsibility Act of 1997), which authorizes public housing agencies that require housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance, and seeks its removal and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, “welfare”) and/or the Supplemental Nutrition Assistance Program (SNAP, “food stamps”) to disclose medical information, including alcohol and other drug use or treatment for addiction or to deny assistance from these programs based on substance use status.


AMA Support for Justice Reinvestment Initiatives: AMA-MSS will ask that our AMA support legislation aimed at improving risk assessment tools, expanding jail diversion and jail alternative programs, streamlining case processing, and increasing access to reentry and treatment programs.

(MSS Res 23, I-15) (AMA Res 205, A-16 Adopted as Amended [H-95.931])

Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States’ Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability: Our AMA-MSS will ask (1) that our AMA advocate that the “deficit-neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and (2) that our AMA study reforms that can be introduced under Section 1332 of the ACA in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same. (MSS Res 07, A-16)

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers: AMA-MSS will ask (1) that our AMA advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; (2) that our AMA support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and (3) that our AMA advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. (MSS Res 22, A-16) (AMA Res 809, I-16 Adopted as Amended [H-100.950]).

Paid Parental Leave: Our AMA-MSS (1) supports policy that extends the length of universal paid parental leave, recommending especially a period of 14 weeks or longer; and (2) supports policies that equally encourage parents of all genders to take parental leave. (MSS Res 10, I-16)

Increased Oversight of Suicide Prevention Training for Correctional Facility Staff: AMA-MSS will ask that our AMA (1) strongly encourage all state and local correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care guidelines; and (2) strongly encourage all state and local correctional facility officers to undergo suicide prevention training annually. (MSS Res 16, I-16) (AMA Res 408, A-17 Adopted as Amended [H-430.984])

Accountability of 911 Emergency Services Funding: AMA-MSS will ask that our AMA encourage federal guidelines and state legislation that protects against reallocation of 911 funding to unrelated services. (MSS Res 40, I-16) (AMA Res 220, A-17 Adopted [H-440.822])

Opposition to Capital Punishment: AMA-MSS opposes all forms of capital punishment. (MSS Res 34, A-17)
270.035MSS
Evaluating Legislation on Substance Disorder Treatment Privacy and Confidentiality: AMA-MSS supports the study of the implications of 42 CFR Part 2 under current law, as well as the proposed alignment of substance use disorder confidentiality requirements with HIPAA, with respect to:

1) Harm due to unwanted disclosure of Substance Use Disorder (SUD) diagnosis and treatment information, including legal, social, emotional, and psychological outcomes;
2) Harm due to non-disclosure of Substance Use Disorder (SUD) diagnosis and treatment information to other health care providers; and
3) Deterrence of patients from seeking treatment for SUDs.
(MSS Res 57-I-17)

270.036MSS
Support for Continued 911 Modernization and the National Implementation of Test-To-911 Service: AMA-MSS will ask the AMA to support the funding of federal grant programs for the modernization of 9-1-1 infrastructure, including incorporation of text to 911 technology. (MSS Res 15, A-18)

275.000MSS
Licensure and Discipline

275.001MSS
Competence for Licensure: AMA-MSS will ask the AMA to: (1) urge state licensing authorities to continue to recognize the NBME certificate; (2) recommend that medical school faculties continue to exercise responsibilities for evaluating students and house-staff; (3) oppose a licensing examination as a requirement for graduates of educational programs accredited by the LCME to enter the first year of graduate training; (4) oppose requirements for licensure requiring a long period of graduate education with the attendant risk of licensure by specialty; and (5) support a single FLEX examination sequence, during or shortly after the first year of graduate medical education. (MSS statement on MSS Res 12, I-81 Recommended amendments to CME Rep B, I-81 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

275.002MSS
Interns' Qualifications: AMA-MSS (1) endorses the concept that an MD degree by an accredited U.S. medical school is a sufficient qualification for the intern to administer medical care as a member of the house-staff treatment team; and (2) opposes any attempts to impose additional requirements (e.g., FLEX I) in order to function as an intern. (MSS Res 11, I-81) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

275.003MSS

275.009MSS
Voting Rights For AMA-MSS NBME Representatives: (1) AMA-MSS will ask the AMA to: (a) petition the NBME to add AMA student representation to the National Board, the governing and voting body of the NBME; (b) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (2) The AMA-MSS Governing Council will pursue avenues to obtain AMA-MSS representation on the NBME Board. (MSS Amended Sub Res 10, I-98) (AMA Res 323, I-98 Adopted [H-295.893]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

275.011MSS
Transfer of Jurisdiction Over Required Clinical Skills Examination to LCME-Accredited and COCA-Accredited Medical Schools: The AMA-MSS will (1) ask our AMA, working with the state medical societies, to advocate for the Federation of State Medical Boards (FSMB) and state medical boards to eliminate the United States Medical Licensing Examination (USMLE) Step 2
Clinical Skills (CS) and the Comprehensive Osteopathic Licensing Examination (COMLEX) Level 2-Performance Examination (PE) as a requirement for Liaison Committee on Medical Education (LCME)-accredited and Committee on Osteopathic College Accreditation (COCA)-accredited medical school graduates who have passed a school administered, clinical skills examination; (2) ask the AMA to amend D-295.998 by insertion and deletion as follows:

**Required Clinical Skills Assessment During Medical School D-295.988**

Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to (1) determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills, and 2) require that medical students attending LCME-accredited institutions pass a school-administered clinical skills examination to graduate from medical school.; and

(3) ask that our AMA advocate for medical schools and medical licensure stakeholders to create guidelines standardizing the clinical skills examination that would be administered at each LCME-accredited and COCA-accredited medical school in lieu of USMLE Step 2 CS and COMLEX Level 2-PE and would be a substitute prerequisite for future licensure exams. (MSS Res 01, A-16 Immediate Transmittal) (AMA Res 321, A-16 Alternate Resolution 311, A-16 Adopted as Amended in Lieu of Res 311, 316, 317, and 321 [ ])

275.012MSS Support A Study on the Minimum Competencies and Scope of Medical Scribe Utilization: AMA-MSS will ask that our AMA partner with The Joint Commission and other stakeholders to study the minimum skills and competencies required of a medical scribe regarding documentation performance and clinical boundaries of medical scribe utilization. (MSS Res 28, A-16)

275.013MSS Equality for COMLEX and USMLE: AMA-MSS will ask the AMA to (1) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (2) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (3) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (MSS Res 38, A-18)

275.014MSS Standardization of Medical Licensing Time Limits Across States: AMA-MSS will ask the AMA to amend H-275.978 Medical Licensure by addition as follows:

Medical Licensure H-275.978

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;

(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;

(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome, and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;

(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;

(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);
(7) urges licensing boards to maintain strict confidentiality of reported information;
(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
(10) urges all physicians to participate in continuing medical education as a professional obligation;
(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;
(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;
(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and
(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

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(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX. (MSS Res 48, I-17) (AMA Res 305, A-18, Referred)
280.001MSS  **Quality of Nursing Homes**: AMA-MSS will ask the AMA to express publicly its concern for inadequate nursing home care, advocate high standards for such care, and support efforts to establish adequate funding of nursing and convalescent homes that would allow them to maintain qualified personnel. (AMA Res 161, A-79 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

285.000MSS  **Managed Care**


290.000MSS  **Medicaid**

290.001MSS  **State Coverage of Medical Formula for Uninsured People Suffering from Phenylketonuria (PKU) Regardless of Age or Gender**: (1) AMA-MSS will promote awareness among health professionals and medical students of Medicaid coverage as it pertains to all PKU patients, regardless of age and gender. (2) AMA-MSS will ask the AMA to encourage state medical societies to support legislation within their jurisdictions that would provide Medicaid funding and coverage of medical formula and foods for Medicaid patients suffering from PKU, regardless of age or gender. (MSS Sub Res 6, I-01) (AMA Res 415, A-02 Adopted [D-290.994]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

290.002MSS  **Interstate Medicaid Cooperation**: AMA-MSS will ask the AMA to (1) support and advocate for legislation allowing out-of-state providers in close proximity to the border to be enrolled as in-state providers in those states that do not currently allow it, using Oregon’s Medicaid system as a model; and (2) support and advocate for legislation that would streamline the provider enrollment process in order to encourage more physicians to become providers for border communities. (MSS Res 28, I-10) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 113, A-11) (Reaffirmed: MSS GC Report A, I-16)

290.003MSS  **Opposition to Medicaid Work Requirements**: AMA-MSS will ask that our AMA oppose work requirements as a criterion for Medicaid eligibility. (MSS Res 29, A-17)

290.004MSS  **Medicaid Coverage of Fitness Facility Memberships**: AMA-MSS will ask the AMA to support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for low-income adult patients. (MSS Res 59, I-17) (AMA Res 109, A-18, Not Adopted)

295.000MSS  **Medical Education**

295.001MSS  **Support Groups**: AMA-MSS will ask the AMA to encourage the development of alternative methods for dealing with the problems of student-physician mental health in medical schools and that these alternatives be available to students at the earliest possible point in their medical education. (AMA Res 164, A-79, Adopted [H-295.999]) (Reaffirmed: CLRPD Rep B, I-89)


295.005MSS Availability of Medical Education: AMA-MSS supports the following principles: (1) A determined, conscientious effort to accept, matriculate, and graduate minority physicians must be undertaken. (2) Support for programs with a commitment to the training of minority medical professionals, particularly the three predominantly black medical schools (Howard, Meharry, Morehouse) must be increased as necessary and maintained. (3) Adequate financial aid packages for minority students must be provided. These may include combinations of grants, loans, scholarships, or service- obligated programs. (4) Efforts should be made to increase the proportion of minorities in medical school faculties and administrative positions. (5) Efforts must be made to improve retention rates of minority students in medical schools. (MSS Position Paper 2, A-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (H-295.992 Rescinded: CME Rep. 2, A-13) (Reaffirmed: MSS GC Rep D, I-15)


295.008MSS Teaching Clinical Medical Ethics: AMA-MSS will ask the AMA to support required medical ethics instruction in medical schools by encouraging medical schools to make medical ethics a part of the required curriculum. (AMA Res 126, A-86, Adopted [H-295.978]) (Reaffirmed: MSS Rep E, I-96)
295.011MSS **Regulation of Medical Student Education Opportunities**: AMA-MSS will ask the AMA to publicly reaffirm its support for the LCME standard for accreditation of undergraduate medical education programs and to oppose legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (AMA Res 142, I-87 Adopted [H-295.974]) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.012MSS **Promotion of Infection Control Procedures in the Medical School Setting**: AMA-MSS will ask the AMA to: (1) encourage training in infection control to occur throughout the medical school curriculum; (2) urge teaching hospitals to be equipped with the necessary supplies to comply with the Center for Disease Control infection control recommendations; and (3) urge medical schools to integrate a student's use of proper infection control techniques in the student's evaluations. (MSS Rep G, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)


295.018MSS **Addition of Instruction on Organ and Tissue Procurement to the Medical Student Curriculum**: AMA-MSS will ask the AMA to encourage the Liaison Committee on Medical Education (LCME) to recommend incorporation into medical schools' curricula content focusing on organ and tissue procurement. (MSS Sub Res 4, I-89) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)


295.027MSS **Adequate Insurance for Medical Students and Residents**: AMA-MSS will ask the AMA to: (1) urge all medical schools to pay for or offer affordable, policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) urge all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) urge medical schools and residency training programs to pay for or offer affordable health insurance to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) urge carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (AMA Res 252, A-91 Referred) (BOT Rep W, I-91 Adopted [H-295.942]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.029MSS **Medical Student Legislative Awareness**: AMA-MSS will recommended that: (1) medical students actively encourage state medical societies to sponsor legislative awareness workshops for students
and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues. (COLRP Rep A, A-91) (AMA Res 14, A-91 Adopted [H-295.953]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


295.035MSS Medical School Waiting Lists: AMA-MSS recommends that prospective medical students keep medical schools informed about their decision-making process with respect to acceptances, including turning back acceptances to medical schools as soon as a decision not to attend has been. (MSS Rep F, A-92) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


295.054MSS Commonwealth Puerto Rican as a Minority Group: AMA-MSS will ask the AMA to recognize all Puerto Ricans, regardless of place of residence (Commonwealth or mainland), as an underrepresented minority when applying to mainland medical schools and convey this policy to the Association of American Medical Colleges and other bodies as appropriate. (MSS Rep C, I-94) (AMA Res 313, A-95 Referred) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


295.057MSS Child Care Resource Information for Medical Students: AMA-MSS will advocate the provision of child care resources at medical schools, including the availability of on-site child care (day and night) as well as information regarding subsidies for child care and information on child care alternatives for those parents who do not use the on-site services or whose institution is unable to accommodate such services. (MSS Amended Sub Res 22, I-94) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.058MSS Suicide Prevention Program for Medical Students: AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H-345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.061MSS Support for Women's Health Training: AMA-MSS supports efforts to promote the multidisciplinary incorporation of women's health education and training across all medical specialties and in medical school, residency training, and continuing medical education. (MSS Sub

Medical Student Impairment Policies: AMA-MSS will ask the AMA to: (1) strongly encourage medical schools that have not yet established policy on medical student impairment and implemented programs to prevent and treat student impairment to do so immediately; and (2) stress to medical schools the importance of increased information and visibility of medical student impairment policy and programs for the student body and that resources should be made readily available to the students throughout medical school and reiterated at the beginning of each year. (AMA Res 303, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Medical Education about Rape Crises: AMA-MSS will ask the AMA to encourage medical schools to incorporate information about rape exam procedures, the rape trauma syndrome, the psychological needs of rape victims, and available rape support groups into their clinical preparation curriculum. (AMA Amended Res 301, I-95 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


Emergency Child Care: AMA-MSS encourages chapters to develop, in conjunction with the medical school, child care network projects or lists of local resources for emergency child care to support medical students with children. (MSS Rep C, A-96) (Reaffirmed: MSS Rep B, I-01) (Modified: MSS GC Report A, I-16)


295.075MSS  
**Preserving Our Investment in the Face of Medical School Class Size Reductions:** AMA-MSS (1) supports protections for medical students and accordant AMA action to ensure proper placement of displaced students in the event of medical school closures or class size reductions that do not allow for natural attrition of those currently enrolled; and (2) supports encouraging the Liaison Committee on Medical Education to develop guidelines for institutions to follow in the event of medical school closure or immediate class size reductions that provide for adequate notification and placement assistance for the affected medical students. (MSS Sub Res 21, A-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.077MSS  

295.078MSS  
**Teaching Domestic Violence Screening:** AMA-MSS will ask the AMA to encourage editors and publishers of medical training literature to include (1) domestic violence screening questions in recommendations and guidelines for conducting a comprehensive medical history and (2) domestic violence intervention and documentation protocols. (Reaffirmed Existing Policy in Lieu of AMA Res 402, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.079MSS  
**Education of Medical Students About Domestic Violence Histories:** AMA-MSS will ask the AMA to continue its support for the education of medical students on domestic violence by advocating that medical schools and post-graduate medical programs immediately begin training students and resident physicians to sensitively inquire about family abuse with all patients regardless of chief complaint or risk. (AMA Amended Res 303, I-96 Adopted [H-295.912]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.081MSS  
**Promoting Culturally Competent Health Care:** AMA-MSS will ask the AMA to encourage medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (MSS Sub Res 6, I-96) (AMA Res 306, A-97 Adopted as Amended [H-295.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.082MSS  
**Respect for Individual Student’s Beliefs:** AMA-MSS will ask the AMA to encourage medical schools to adopt a policy whereby medical students would be allowed, without penalty, to withdraw from participating in medical procedures that may be violative of personally held moral principles or religious beliefs, provided that the students receive a satisfactory knowledge of the principles associated with the procedure and that the medical schools establish their own guidelines concerning specific procedures and situations in order to avoid the potential of abuse. (MSS Sub Res 7, I-96) (AMA Res 304, A-97 Referred) (CME Rep 4, A-98 Adopted in Lieu of Res 304 [H-295.896]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.083MSS  
**Cardiopulmonary Resuscitation and Basic Life Support Training for First Year Medical Students:** AMA-MSS will ask the AMA to strongly encourage training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. (MSS Res 14, I-96) (AMA Res 305, A-97, Adopted [H-295.906]) (Reaffirmed: MSS

Status of Graduates of Puerto Rico LCME Medical Schools: AMA-MSS will direct its liaison to the LCME to remind U.S. medical schools and residency programs that LCME accredited schools in the Commonwealth of Puerto Rico are considered part of the U.S. educational system and not that of a foreign entity and that students from these programs should be treated as U.S. students. (MSS Sub Res 17, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

FREIDA Online: AMA-MSS will promote the use of AMA FREIDA Online. (MSS Rep D, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B-I-13)


Support for the Accreditation of US Medical Schools: AMA-MSS recommends that as new medical schools are established in the US, they should be encouraged to apply for LCME or AOA accreditation. (2) AMA-MSS will join efforts to educate the public, physicians, health policy leaders, educators, and elected officials about the need to maintain quality standards in medical education. (3) AMA-MSS will encourage and will ask the AMA to encourage efforts to educate all prospective medical students about the potential implications of attending any non-LCME/AOA accredited medical school. (MSS Amended Sub Res Late 6, I-98) (AMA Amended Res 322, I-98 Adopted [H-295.892]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Privacy and Confidentiality of Medical Students in Physical Diagnosis Classes: AMA-MSS supports the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles: (1) If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without his or her explicit, meaningful, and non-coerced consent; (2) No information regarding abnormal physical findings encountered on a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent. (MSS Late Res 1, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

HIV Post-Exposure Prophylaxis for Medical Students During Electives Abroad: AMA-MSS will ask the AMA to: (1) recommend that U.S. medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV post-exposure prophylaxis, and that the schools assume financial responsibility for providing or obtaining PEP when not otherwise covered; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. (MSS Amended Res
295.110MSS

US Medical Student Match Fees: AMA-MSS strongly encourages the NRMP staff to develop and implement an equitable NRMP Match fee structure for both U.S. Medical Students and Independent Applicants that appropriately reflects actual costs for each group. (MSS Sub Late Res 1, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.111MSS

State Society and State Medical Board Support to Delay Implementation of the USMLE Clinical Skills Assessment Exam: AMA-MSS will ask the AMA to: (a) commend the LCME for making clinical skill competencies a priority, (b) work with the AAMC and LCME to assure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum, and (c) encourage all LCME accredited medical schools to adopt as policy that all medical students at their institutions pass an OSCE or CSAE as part of the matriculation requirements for the conferring of an MD degree. (MSS Late Res 1, A-02) (AMA Sub Res 308, A-02, Adopted [D-295.968]) (Amended: MSS Rep C, I-07) (D-295.968 Rescinded: CCB/CLRDP Rep. 4, A-12) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.114MSS

Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation: (1) AMA-MSS will ask the AMA to: (a) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam (USMLE) Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (b) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (c) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first 5 years of the implementation of the exam; (d) encourage medical schools to reevaluate their educational programs to ensure appropriate emphasis of clinical skills training in medical schools; (e) study, in conjunction with the NRMP, AOA, AGCME, and other interested organizations, the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education; (f) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 4 months; and (g) monitor in an ongoing fashion, the implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum. (2) AMA-MSS will study safeguard measures for students in the first five years of implementation of the Clinical Skills Assessment Exam and COMLEX-PE; (MSS Res 7, A-03) (AMA Amended Res 324, A-03 Adopted in Lieu of Resolution 315 [D-275.985]) (Amended: MSS Rep E, I-08) (D-275.985 Rescinded: CME Rep. 2, A-13) (Reaffirmed: GC Rep B, I-13)

295.115MSS

Support of Business of Medicine Education for Medical Students: AMA-MSS will ask the AMA to encourage all US medical schools to provide students with a basic foundation in medical business, drawing upon curricular domains referenced in Undergraduate Medical Education for the 21st Century (UME-21), in order to assist students in fulfilling their professional obligation to patients and society in an efficient, ethical, and cost-effective manner. (MSS Res 1, I-03) (AMA Res 305, A-04 Adopted [D-295.958]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (D-295.958 Rescinded: CME Rep. 2, A-14)
295.116MSS  Opposition to Clinical Skills Examinations for Physician Medical Re-Licensure: AMA-MSS will ask the AMA to: (1) oppose clinical skills examinations for the purpose of physician medical re-licensure until such examinations can be shown to accurately predict physician clinical incompetence or moral turpitude; (2) reaffirm its support for continuous quality improvement of practicing physicians; and (3) support research into methods to improve clinical practice, including practice guidelines and continue to support the implementation of quality improvement through local professional, non-governmental oversight. (MSS Res 13, I-03) (AMA Amended Res 307, A-04 Adopted in lieu of AMA Res 313 [H-275.930]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

295.117MSS  Additions to United States Medical Licensure Examination and College of Osteopathic Medical Licensure Exam: AMA-MSS will ask the AMA to oppose additions to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam that lack predictive validity for future performance as a physician and work with appropriate organizations toward requiring consensus approval by professional medical organizations for implementation of additions or modifications to the United States Medical Licensure Examination and College of Osteopathic Medical Licensing Exam. (MSS Res 14, I-03) (AMA Amended Res 308, A-04 Adopted [H-275.929]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)


295.122MSS  Modernization of Medical Education Assessment and Medical School Accreditation: AMA-MSS will ask the AMA to: (1) vigorously work to establish medical education system reforms throughout the medical education continuum that demand evidence-based teaching methods that positively impact patient safety or quality of patient care; and (2) work with the Liaison Committee on Medical Education (LCME) to perform frequent and extensive educational outcomes assessment of specialized competencies in the medical school accreditation process at minimum every four years, requiring evidence showing the degree to which educational objectives impacting patient safety or quality of patient care are or are not being attained. (MSS Res 9, A-04) (AMA Res 818, I-04 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS Resolution 01, A-19)

295.123MSS  Teaching and Evaluating Professionalism in Medical Schools: AMA-MSS will ask the AMA to: (1) strongly urge the Liaison Committee on Medical Education to promptly create and enforce uniform accreditation standards that require all LCME- accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the Liaison Committee on Medical Education to develop competencies for professional behavior and a mechanism for outcome assessment at least every four years in the accreditation process, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME-accredited medical schools; continue its efforts to teach and evaluate professionalism during medical education; and (4) actively oppose, by all available means, any attempt by the NBME and/or FSMB to add separate, fee-based examinations of behaviors of professionalism to the United States Licensing Examinations. (MSS Res 10, A-04) (AMA Amended Res 304, A-05 Adopted [D-295.954]) (Reaffirmed: MSS GC Report B, I-09) (D-295.954 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16)
295.126MSS  Medical Student Clinical Training and Education Conditions: AMA-MSS will ask the AMA to: (1) commend the LCME for addressing the issue of the medical student learning environment including student clerkship hours; (2) urge the LCME to adopt specific medical student clinical training and educational guidelines for the clerkship years including: (a) No more than one night on call every three nights; (b) No more than 80 hours total of clinical training and education time per week averaged over four weeks; and (c) No more than 24 consecutive hours on call; and (2) recommend that the LCME revisit the issue of medical student clinical training and education conditions every five years for revision. (MSS Res 16, I-03 Referred) (AMA Res 310, A-04 Referred) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

295.129MSS  Improving Sexual Education in the Medical School Curriculum: AMA-MSS will ask the AMA to: (1) encourage all medical schools to train medical students to be able to take a thorough and non-judgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) issue a public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces the AMA’s commitment to helping patients maintain sexual health and well-being. (MSS Res 8, I-04) (AMA Res 306, A-05 Withdrawn) (AMA Res 314, A-05 Adopted [H-295.879]) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

295.130MSS  Educating Medical Students about the Pharmaceutical Industry: AMA-MSS will ask the AMA to: (1) strongly encourage medical schools to include unbiased curricula concerning the impact of direct-to-consumer marketing practice employed by the pharmaceutical industry, as they relate to the physician-patient relationship; and (2) strongly encourage medical schools to include unbiased information in their curricula concerning the pharmaceutical industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, and (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision-making process involved in prescribing medications specifically using evidence-based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (MSS Sub Res 15, I-04) (AMA Res 303, A-05 Adopted [D-295.955]) (Modified: MSS GC Report B, I-09) (D-295.955 Rescinded: CME Rep. 1, A-15) (Reaffirmed: MSS GC Report A, I-16)

295.131MSS  Equal Fees for Osteopathic and Allopathic Medical Students: AMA-MSS will ask the AMA to: (1) reaffirm AMA Policies H-405.989 and G-635.053; (2) discourage discrimination by institutions and programs based on Osteopathic or Allopathic training; (3) support equal fees for clinical rotation externships by Osteopathic and Allopathic medical students; and (4) encourage that LCME/ACGME accredited institutions maintain fair practice standards for equal access to all US medical students, Osteopathic and Allopathic (MSS Amended Res 3, A-05) (AMA Res 809, I-05 R1 Adopted, R2 Adopted as Amended, R3 and R4 Referred [H-295.876]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.132MSS  Implementation of a Second Match: The AMA-MSS Governing Council will work collaboratively with the National Resident Matching Program (NRMP) to improve the scramble and study the logistics of a second Match (MSS Sub Res 4, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.133MSS  Instruction of Effective Teaching Methods in Medical School Curricula: AMA-MSS will encourage the Liaison Committee on Medical Education to recommend that medical schools include instruction on effective teaching methods in their curricula. (MSS Res 8, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)
295.134MSS Relocation of Medical Students in the Event of Emergency: AMA-MSS supports the formation of protocols by individual medical schools to relocate and temporarily or permanently assimilate medical students into other medical schools in the event of a crisis or natural disaster resulting in the closing of their medical school. (MSS Res 9, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


295.136MSS Combining the AOA and ACGME Resident Matching Programs: AMA-MSS will request that the NRMP explore the possibility of combining the AOA and the NRMP match and that the AMA-MSS await the report of the American Osteopathic Association House of Delegates on combining the AOA and NRMP match programs and continue to monitor the final actions of the various osteopathic governing bodies. (MSS Rep A, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.137MSS Expansion of Student Health Services: AMA-MSS will ask the AMA to: (1) strongly encourage all medical schools to establish student health centers in order to provide adequate and timely medical and mental health care to their students; and (2) encourage medical schools to increase their student health center’s hours to include weekend coverage. (MSS Rep D, I-05, AMA Res 309, A-06, Referred) (CME Rep 6, A-07 Adopted [H-295.956]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

295.138 MSS Medical Spanish Electives in Medical School Curriculum: AMA-MSS will ask the AMA to strongly encourage all accredited U.S. medical schools to offer medical second languages, especially medical Spanish, to their students as an elective. (MSS Res 2, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.139 MSS Standardization of Medical Student Background Checks: AMA-MSS (1) will collaborate with the appropriate organizations to ensure the standardization of medical student criminal background checks throughout all LCME and AOA accredited medical schools; and (2) will work with the appropriate organizations to ensure that medical student criminal background checks are structured to maintain the student’s confidentiality, as well as avoid excessive frequency, cost, and duplicity as students rotate through clinical sites. (MSS Res 4, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Modified: MSS GC Report A, I-16)

295.140MSS Written Maternity Policies: A New LCME Accreditation Standard: AMA-MSS will urge the Liaison Committee on Medical Education to add maternity, paternity, and adoption leave policies as an accreditation standard or annotation. (MSS Res 8, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

295.141MSS Changing the Culture of Health Care Delivery: Encouragement of Teamwork Among Health Care Professional Students: (1) AMA-MSS will ask the AMA to recognize that interprofessional education and partnerships are a top priority of the American medical education system; (2) AMA-MSS will ask the AMA to explore the feasibility of the implementation of LCME and AOA accreditation standards requiring inter-professional training in medical schools. (MSS GC Report A, A-07) (AMA Res 308, A-08 Adopted as Amended [D-295.934]) (Modified: MSS GC Report C, I-12) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-17)
295.142MSS Communication and Clinical Teaching Curricula: (1) AMA-MSS (a) supports the development of formalized medical teacher training for residents and attending faculty and (b) will ask the AMA to establish policy supporting the development of formalized medical teacher training for residents and attending faculty. (MS GC Report B, A-07) (AMA Res 804 Referred) (Modified: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.144MSS Support for Family and Relationships During Medical School and Residency: (1) AMA-MSS will work with the RFS, the AMA Alliance, and other interested organizations to (a) urge medical schools and residency programs to provide access to and encourage use of relationship counseling; (b) encourage medical schools and residency programs to offer workshops, activities, or lectures regarding the balance of family life with medical training and practice; and (c) promote opportunities for student and resident spouses and partners to become involved in the medical community, particularly through the AMA Alliance. (MSS Amended Res 13, I-07) (Modified: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.145MSS One Health: AMA-MSS will engage in dialog with the Student American Veterinary Medical Association to promote collaboration with the public health and veterinary professional and educational communities. (MSS Res 12, A-08) (Modified: GC Rep B, I-13)

295.147MSS Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year: AMA-MSS will ask the AMA to (1) strongly encourage the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA) accredited medical schools; (2) support and encourage the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school; (3) encourage the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation, continue to have a mechanism for accepting such applications of osteopathic medical students; and (4) explore the feasibility of collaborating with other stakeholder organizations and funding agencies to convene leaders in allopathic and osteopathic medicine responsible for undergraduate and graduate medical education, accreditation and certification, to explore opportunities to align education policies and practices, including visiting student elective opportunities. (MSS Amended Res 2, A-09) (AMA Res 910, I-09 [H-295.867]) (Reaffirmed: MSS GC Rep A, I-14)

295.149MSS Competency-Based Portfolio Assessment of Medical Students: AMA-MSS will ask the AMA to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment. (MSS Sub Res 7, I-09) (AMA Res 314, A-10 Adopted [D-295.318]) (Reaffirmed: MSS GC Rep A, I-14)

295.150MSS USMLE Exam Fee Burden: AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students. (MSS Res 4, A-10) (Reaffirmed, MSS GC Rep D, I-15)

295.151MSS Including Elements of the Patient-Centered Medical Home Model in Medical Education: AMA-MSS encourages medical schools and residency programs to incorporate elements of the patient-centered medical home model, as defined by the AMA’s Joint Principles of the Patient Centered Medical Home, into medical education. (MSS Res 7, A-10) (Reaffirmed MSS GC Rep D, I-15)
295.152MSS  Medical Student Access to Electronic Medical Records: AMA-MSS will ask the AMA to encourage teaching hospitals and other clinical clerkship sites to allow medical student access to patient electronic medical records. (MSS Res 8, A-10) (AMA Amended Res 5, I-10 Adopted [D-315.979]) (Reaffirmed, MSS GC Rep D, I-15)

295.153MSS  Health Policy Education in Medical Schools: AMA-MSS will monitor progress on the development of the Association of American Medical College's behavioral and social science core competencies and report back upon release of the competencies. (GC Rep D, A-10) (Amended: MSS Res 2, I-11) (Reaffirmed, MSS GC Rep D, I-15)

295.154MSS  Encouraging the Inclusion of Preclinical Longitudinal Clinical Experiences in the Medical Education Curriculum: AMA-MSS will ask the AMA to encourage medical schools to include longitudinal clinical experiences for students during the “preclinical” years of medical education. (MSS Res 6, I-10) (AMA Res 309, A-11 Adopted [D-295.960]) (Reaffirmed: MSS GC Rep D, I-15)

295.155MSS  Global Health Education: AMA-MSS will ask the AMA to (1) recognize the importance of global health education for medical students; and (2) encourage medical schools to include global health learning opportunities in their medical education curricula. (MSS Res 9, I-10) (AMA Res 310 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

295.156MSS  Medical School International Service Learning Opportunities: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical school international service-learning opportunities are structured to contribute meaningfully to medical education and that medical students are appropriately prepared for these experiences; and (2) work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and other relevant organizations to ensure that medical students participating in international service-learning opportunities are held to the same ethical and professional standards as students participating in domestic service-learning opportunities. (MSS Res 13, I-10) (AMA Res 307 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

295.157MSS  Encouraging Medical Student Professionalism: Affirming Institutional Financial Disclosure Policies During Undergraduate Medical Education: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage the Liaison Committee on Medical Education and the American Osteopathic Association Commission on Osteopathic College Accreditation to require all medical schools to make known to students the existence of the physician-industry financial disclosure database(s) that exist as required by the Patient Protection and Affordable Care Act (H.R. 3590 Section 6002); and (2) work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to encourage all medical school faculty to model professional behavior to students by disclosing the existence of financial ties with industry, in accordance with existing disclosure policies at each respective medical school. (MSS Res 16, I-10) (Reaffirmed: MSS Res 11, A-11) (AMA Res 308, A-11 Adopted [D-140.981]) (Modified and Reaffirmed: MSS GC Report A, I-16)

295.158MSS  Access to Vaccinations for Student and Healthcare Workers: AMA-MSS recommends (1) That all medical schools provide all institutionally required vaccinations to health professions students, with implementation costs to be part of student fees, unless medically contraindicated; and (2) That hospitals provide necessary access to vaccinations for their healthcare personnel. (MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)
295.161MSS Transition from “Scramble” to Supplemental Offer and Acceptance Program: AMA-MSS will ask the AMA to encourage the National Resident Matching Program to study the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and to include stratified analysis by specialty and other relevant areas. (MSS Res 15, A-11) (AMA Res 920, I-11 Adopted as Amended [D-310.977]) (Reaffirmed: MSS GC Report A, I-16)

295.162MSS Transparency in the NRMP Match Agreement: AMA-MSS will ask the AMA to (1) ask the National Resident Matching Program to publish all statistics on waivers and violations with subsequent consequences for both programs and applicants, thereby encouraging match integrity and in violation repercussions; and (2) advocate for the word “training” in section 7.2.1 of the NRMP match agreement be changed to “residency training,” and specifically state that NRMP cannot prevent an applicant from maintaining their education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs. (MSS Res 16, A-11) (AMA Res 918, I-11 Adopted as Amended and Second Resolve Clause Referred [D-310.974]) (Reaffirmed: MSS GC Report A, I-16)

295.164MSS Medical Student Access to Comprehensive Mental Health and Substance Abuse Treatment: AMA-MSS strongly encourages the Association of American Medical Colleges and the Liaison Committee on Medical Education to conduct research into the number of US medical students with mental health and/or substance abuse concerns who either: 1. do not seek treatment due to the cost involved, or 2. have sought treatment, but do not feel that it has been adequate due to yearly visit and dollar limits placed on their care by their insurance plan. (MSS Res 3, I-11) (Reaffirmed: MSS GC Report A, I-16)


295.166MSS Expanding Clerkship Site Access to Include U.S. Medical Schools Undergoing Accreditation: AMA-MSS will ask the AMA to amend Policy D-295.320 by insertion as follows:

D-295.320 Factors Affecting the Availability of Clinical Training Sites for Medical Student Education

Our American Medical Association will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.

295.167MSS Quality Improvement Education in Medical Schools and Residency Programs: AMA-MSS will (1) advocate to medical school deans for the inclusion of quality improvement education in medical school curricula; (2) encourage the American College of Medical Quality, the Association of American Medical Colleges, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, the Commission on Osteopathic Colleges Accreditation, and other relevant bodies to develop a basic set of core competencies in medical quality improvement that all medical school curricula should include; (3) encourage the American College of Medical Quality and other appropriate organizations to develop a guideline curriculum in medical quality improvement to be made available to medical schools; and (4) work with relevant parties to monitor the national implementation of quality improvement education in medical school curricula and report back to the Medical Student Section. (MSS Res 4, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.168MSS Expansion of Medical Spanish in US Medical Schools: AMA-MSS will encourage the AAMC, LCME, COCA, and AOA to identify and evaluate existing ways that schools incorporate medical Spanish and other non-English languages into their curricula and report successful strategies for improved proficiency to be used as guidelines for US accredited medical schools. (MSS Res 6, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.169MSS Eliminating Legacy Admissions: AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the AAOA to remove any questions on secondary applications pertaining to legacy status. (MSS Res 8, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.170MSS Supporting Two-Interval Grading Systems for Medical Education: AMA-MSS acknowledges the benefits of a two-interval grading system in medical colleges and universities for the non-clinical curriculum. (MSS Late Res 2, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.171MSS Health Policy Education in Medical Schools: (1) AMA-MSS encourages medical schools to implement teaching strategies that promote outcome based development of behavioral and social science foundations for medical students; and (2) AMA-MSS encourages the AAMC to engage in appropriate follow-up research based on the implementation of its behavioral and socioeconomic report competencies. (GC Rep B, A-12) (Reaffirmed: MSS GC Report A, I-17)

295.172MSS Insurance Education for Medical Students: AMA-MSS will ask the AMA to work with the AAMC, AACOM, LCME, and COCA to encourage integration of medical educational curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician’s role in obtaining affordable care for patients. (MSS Res 5, I-12) (Reaffirmed: MSS GC Report A, I-17)

295.173MSS Policy and Advocacy Rotations for Medical Students: AMA-MSS will ask the AMA to (1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and (2) work with state and specialty societies, the AAMC, AACOM, COCA, LCME, and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies. (MSS Res 6, I-12) (Sub AMA Res 301, A-13 Adopted [H-295.864]) (Reaffirmed: MSS GC Report A, I-17)

295.174MSS Evaluation of Standardized Clinical Skills Exams: AMA-MSS will ask the AMA to (1) evaluate the benefits and consequences of the implementation of the standardized clinical skills exams as a step for licensure and provide recommendations based on these findings; and (2) evaluate the consequences of the January 2013 changes to the USMLE Step II Clinical

295.175MSS Medical Student Mistreatment: AMA-MSS will encourage medical schools to have procedures in place for students to report incidents of mistreatment without fear of retaliation and that instructions on how to report incidents should be explained to students at the beginning of medical school and again before starting rotations. (MSS Res 3, I-13)

295.176MSS Unified Medical Education: AMA-MSS supports a Unified Accreditation System for allopathic and osteopathic graduate medical education programs. (MSS Res 5, I-13)

295.177MSS Shared Decision-Making in Medical Education: AMA-MSS will ask the AMA to (1) amend policy D.373.999 by insertion as follows:

D-373.999 Informed Patient Choice and Shared Decision Making

(1) Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care; and

(2) Collaborate with the appropriate medical education organizations to develop undergraduate medical education recommendations that ensure proficiency in shared decision making and effective use of shared decision-making tools, such as patient decision aids. (MSS Res 21, I-13)

295.178MSS Motivational Interviewing in Medical Education: AMA-MSS supports the incorporation of motivational interviewing into medical school curriculum. (MSS Res 27, I-13)

AMA Support for Increasing Access to Shadowing Opportunities for Premedical Students: AMA-MSS encourages state medical societies to create a database of physicians willing to provide shadowing opportunities to undergraduate students. (MSS Res 37, A-14)
295.180MSS  Promoting Education of Electronic Health Records in Undergraduate Medical Education: AMA-MSS will ask the AMA to support efforts to incorporate electronic health records training into undergraduate medical education. (MSS Res 7, A-14) (AMA Res 907, I-14 Referred)

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

295.182MSS  USMLE Step 1 Timing: AMA-MSS will ask the AMA to ask the NBME to track USMLE Step 1 exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 exam performance. (MSS Res 20, A-14) (AMA Res 911, I-14 Adopted as Amended [D-275.958])

295.183MSS  Combating Sex-Linked Discrimination of Denying Special Request for Lactation during Medical Board Examination: AMA-MSS will ask the AMA to: (1) urge all medical examination agencies to grant special request to give breast feeding test-takers additional break time and a suitable environment during the medical licensing examination to express milk; and (2) encourage all medical examination agencies to serve as role models to improve public health by supporting mothers who provide breast milk to their infants. (MSS Res 42, A-14) (Substitute AMA Res 903, I-14 Adopted with Change in Title [H-295.861])

295.184MSS  Medical Student Involvement in Handoffs: AMA-MSS (1) recognizes the importance of medical student involvement in patient handoffs as integral to both comprehensive medical education and quality patient care; and (2) encourages supervised medical student involvement in patient handoffs. (MSS Res 9, I-14)

295.185MSS  Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages: AMA-MSS will ask that the AMA study the issue of Deferred Action for Childhood Arrivals (DACA)-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. (MSS Late Res 4, I-14)

295.186MSS  Addressing Communication Deficits in Medical School Curricula: AMA-MSS supports the development and implementation of innovative, integrated technologically current and evidence-based methods to teach and evaluate patient-centered communication. (MSS Res 2, I-15)

295.187MSS  Promoting and Reaffirming Domestic Medical School Clerkship Education: AMA-MSS will ask (1) that our AMA pursue avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; (2) that our AMA support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and (3) that our AMA reaffirm policies D-295.320, D-295.931, and D-295.937. (MSS Res 18, A-16)

295.188MSS  Future of the United States Medical Licensing Examination (USMLE): Examining Multi-Step Structure and Score Usage: AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational science and
clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams. (MSS Res 21, I-16) (AMA Res 309, A-17 Adopted as Amended [ appended to H-275.962 and H-275.953])

295.189MSS Encouraging Lifestyle Medicine in Undergraduate Medical Education: AMA-MSS supports the teaching of Lifestyle Medicine in undergraduate medical education. (MSS Res 41, I-16)

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

295.191MSS Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients: AMA-MSS will ask that our AMA amend policy H-160.991 by insertion and deletion to read as follows:

**Healthcare Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991**

Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and female-to-male transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk of sexually transmitted diseases.

(MSS Res 14, A-17)

295.192MSS Medical Student Involvement and Validation of the Standardized Video Interview Implementation: AMA-MSS will ask the AMA to (1) work with the Association of American Medical Colleges and its partners to assure that medical students and residents are recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and (2) advocate for delaying expansion of the Standardized Video Interview until published data demonstrates the efficacy and utility of the Standardized Video Interview as a mandatory residency application requirement. (MSS Res 16, I-17)

295.193MSS Implicit Bias and Its Effects on healthcare and Its Incorporation into Undergraduate Medical Education: AMA-MSS (1) recognizes the existence of implicit bias among health care clinicians; (2) recognizes implicit bias affects treatment and clinical outcomes of patients based on their social identities; and (3) supports medical schools in their effort to include implicit bias training into undergraduate medical education to ensure graduating medical students are better prepared to deal with implicit bias in the treatment of patients. (MSS Res 07, I-17)
295.194MSS Anti-Racism Competencies in Undergraduate Medical Pre-Clinical Curriculum: AMA-MSS (1) recognizes that structural racism, systemic discrimination, and the historical and current discriminatory legislative policies in the US impact health, access to care, and health care delivery, in manners that are distinct from individual and interpersonal discrimination and implicit bias; and (2) supports undergraduate medical education that includes historical practices within the medical field that have affected communities of color in the US and their relationships with the medical community, including but not limited to medical experimentation. (MSS Res 74-I-17)

Introducing Teach-back Education into Medical School Curriculum: AMA-MSS supports the training of the teach-back technique in medical schools. (MSS Res 34, I-18)

295.195MSS Increasing Access to Trauma-Informed Services within Schools: AMA-MSS will ask the AMA to (1) encourage physicians, residents and medical students to utilize current integrated care approaches that engage school-based trauma informed services; and (2) encourage stakeholders to implement trauma-informed school-based services. (MSS Res 35 I-18) (AMA Res 504, A-19, Combined with Res 526 and Adopted [H-515.952])

Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools: AMA-MSS will ask the AMA to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved. (MSS Res 37 I-18) (AMA Res 322, A-19, Adopted as amended and with Title Change [H-295.856])

295.196MSS Engaging Stakeholders for Establishment of Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools: AMA-MSS will ask the AMA to amend policy H-295.866 as follows:

Supporting Two-Interval Grading Systems for Medical Education H-295.866

Our AMA will work with stakeholders to encourage the establishment of acknowledges the benefits of a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (MSS Res 13, A-19)

295.197MSS Strengthening Standards for LGBTQ Medical Education: AMA-MSS will ask the AMA to amend policy H-295.878, Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education by insertion and deletion to read as follows:

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

(MSS Res 16, A-19)

295.200MSS Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations: AMA-MSS will ask the AMA to work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and general a report with the findings by I-20. (MSS Res 45, A-19)

305.000MSS Medical Education: Financing and Support

305.038MSS AMA-ERF Medical School Contributions: (1) AMA-MSS will ask the AMA to communicate to medical schools the importance of providing an annual accounting to state societies of how AMA Education and Research Foundation (AMA-ERF) funds are distributed. (2) AMA-MSS will encourage MSS chapters to assist the Alliance with the yearly fundraising efforts for AMA Education and Research Foundation (AMA-ERF) funds. (MSS Sub Res 40, A-95) (AMA Sub Res 601, I-95 Adopted) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

305.039MSS A Voucher-Based Mechanism for Residency Position Funding: (1) AMA-MSS supports the establishment of a voucher system to provide entry eligibility for residents into graduate medical education programs and concurrently provide funding eligibility for the training program at the site where training occurs. (2) AMA-MSS supports the voucher system for funding of graduate medical education training positions for all graduates of US LCME and AOA-accredited medical schools with additional vouchers provided on a competitive basis to International Medical Graduates in a number determined by a public/private sector workforce planning group. (MSS Rep C, I-96) (CME Amended Rep 1, I-96 Adopted) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)

305.043MSS Tax Exemption for National Health Service Corps Scholarship: AMA-MSS supports federal legislation that will assure that tax-exempt status is returned to the direct medical school expense portion of the National Health Service Corps Scholarship program. (MSS Late Res 4, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)
305.054MSS  Refinancing Federal Consolidation Loans: AMA-MSS will ask the AMA to support the refinancing of Federal Consolidation Loans and actively advocate for legislation that provides the opportunity to refinance Federal Consolidation Loans. (MSS Res 7, I-03) (AMA Res 849, I-03 Adopted [D-305.981]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

305.058MSS  AMA-MSS Medical Student Loan & Financial Aid Online Education Resource: (1) AMA-MSS will ask the AMA to reaffirm AMA Policies H-305.989 and H-305.996. (2) AMA-MSS will request that each medical school provide to the MSS its own up to date online resource explaining prior to enrollment its loan disbursement procedures and any private loans the school may offer. (MSS Sub Res 1, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

305.060MSS  Solutions to Tackling the Increasing Cost of Medical Education: AMA-MSS will ask the AMA to (a) support policies that ensure that funding gained by medical schools from all future increases to medical school tuition and fees be allocated directly to improve the education of medical students; and (b) support policies that ensure that all information related to the allocation of funds from tuition and fees increases be disclosed to all prospective and current medical students for each respective medical school campus; (2) AMA-MSS will work to develop print and electronic resources for our local chapters to utilize on their campuses to encourage their medical school deans to adopt policies that ensure transparency in medical school tuition and fees increases; (3) The AMA-MSS Governing Council will (a) continue to work with our AMA Council on Medical Education, the Association of American Medical Colleges (AAMC), and the AAMC Organization of Student Representatives (OSR) to encourage medical schools to adopt policies that ensure that all increases to medical school tuition and fees go towards direct improvements to medical student education. (MSS Amended Report G, A-07) (AMA Sub Res 310, A-08 Adopted) (Modified: MSS GC Rep C, I-12) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-17)

305.061MSS  Student Loan Empowerment: AMA-MSS will ask the AMA to support legislation that requires medical schools to inform students of all government loan opportunities along with private loans and requires disclosure of reasons that preferred lenders were chosen. (MSS Amended Res 16, I-07) (AMA Res 307, A-08, Adopted as Amended [H-295.869]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

305.062MSS  Industry Support of Professional Education in Medicine: AMA-MSS encourages aggressively decreasing reliance on industry support for medical education and support alternative funding mechanisms to finance quality medical education. (MSS Res Late 4, A-08) (Reaffirmed: GC Rep B, I-13)

305.067MSS  Eligibility Criteria for AMA Foundation Scholarships: AMA-MSS will formally ask the AMA Foundation to consider allowing non-U.S. citizens attending U.S. medical schools to apply for AMA Foundation scholarships. (MSS Res 2, I-10) (Reaffirmed: MSS GC Rep D, I-15)

305.072MSS  Financial Aid Dependency Status of Medical Students: AMA-MSS will (1) encourage medical schools to institute an appeals procedure that allows individual students with extenuating familial circumstances to apply for institutional financial aid without parental tax information taken into consideration, such as students whose non-custodial parent’s whereabouts are unknown or students who have an established history of non-support from their parents; and (2) work to ensure adequate dissemination of information on educational funding sources available to medical students. (GC Rep A, I-11) (Reaffirmed: MSS GC Report A, I-16)
305.077MSS  Increasing Public Service Opportunities for Specialists: AMA-MSS will ask the AMA to (1) encourage the National Health Service Corps and other relevant stakeholders to expand their scope and encourage the participation of specialists in order to ensure the provision of services in underserved communities; (2) work with state and federal governments, medical schools, the AAMC, and other relevant entities to encourage new loan forgiveness programs for specialists treating underserved patient populations; and (3) that our AMA urges states who opt-out of the ACA expansion of Medicaid to still comply with the increased reimbursement schedule for specialists treating Medicaid patients. (MSS Res 12, I-12) (AMA Policies D-200.978, D-200.980, D-200.982, D-200.985, H-200.954, D-305.960, D-305.973, D-305.975, D-305.979, D-305.993 and H-305.928 Reaffirmed in Lieu of Res 202, A-13) (Reaffirmed: MSS GC Report A, I-17)

305.081MSS  Addressing Student Debt in Medical School Attrition Due to Mental Illness: AMA-MSS supports the study of mechanisms for dismissing federal loan obligations for students who withdraw from medical school due to a diagnosed mental and/or physical illness. (MSS Res 13, A-18)

305.082MSS  Understanding Philanthropic Efforts to Address Medical School Tuition: AMA-MSS will (1) study the financial sustainability and factors enabling the implementation of tuition-free and tuition-reduced undergraduate medical education programs; and (2) study the efficacy of using tuition-free and tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students. (MSS Res 29, I-18)

305.083MSS  MSS Financial Burden of Application to Medical School and Residency: The AMA-MSS recognizes the financial burden associated with applying to and attending medical school and applying to residency, and supports the following principles:

1. AMA MSS supports the incorporation of admissions practices that objectively evaluate applicants’ behavioral competencies into future AMA medical education funding initiatives.
2. That the AMA-MSS will ask the AMA to (a) support medical school admission policies that do not discriminate against students who may require financial aid to pursue a medical education; (b) encourage all US medical schools to adopt an active policy of informing medical school applicants of estimated tuition and fees for each year of undergraduate medical education and the sources of financial aid available; and (c) continue to encourage the maintenance and development of resources, both public and private, to help meet the financial needs of students attending American medical schools.
3. That the AMA-MSS will ask our AMA to consider the following strategies to address the high cost of interviewing for residency: (a) establishing a method of collecting data on interviewing costs for medical students of all specialties (e.g., NRMP survey collaboration) for further study, (b) supporting further study of residency interview strategies aimed at mitigating costs associated with residency interviews, (c) producing and providing a toolkit of recommended resources for 4th year medical students who are interviewing on the AMA-MSS webpage, (d) creating and/or promoting specific websites related to med student travel, and (e) providing or recommending and online forum where students can accommodate other medical students who are interviewing in their area.

(MSS GC Rep A., I-17)

305.084MSS  Medical School Tuition: The AMA-MSS supports the following principles regarding medical school tuition:

1. That the AMA-MSS joins the AMA in its opposition of mid-year and retroactive medical school tuition and retroactive medical school tuition or fee increases and encourages collaborations in this oppositions, including the AAMC.
2. That the AMA-MSS will ask the AMA to study, in collaboration with state, specialty, and other interested organizations, the case precedent, timing, risks, and other considerations in filing an application for injunctive relief to block retroactive or mid-year tuition increase.

3. That the AMA-MSS will encourage state and county medical societies to develop policy and lobby state legislatures to help restrain medical school tuition increases including, but not limited to, state subsidies to public and private medical schools within their state.

4. That the AMA-MSS endorses the concept that medical schools should guarantee that tuition will not be raised by more than a certain modest percentage for students already enrolled and that any additional tuition increases that may be necessary should be imposed on the entering class.

5. That the AMA-MSS joins the AMA in its opposition of medical school tuition taxes and any other attendance-based taxes imposed on medical students by any government entity.

6. That the AMA-MSS will ask the AMA to discourage U.S. medical schools from requiring accepted international students to pay more than a single term’s tuition at each billing period, in the same manner as the rest of the U.S. citizens and permanent U.S. residents within the student body.

(MSS GC Rep A, I-17)

305.085MSS Medical Students Federal Loans: The AMA-MSS supports the following principles regarding federal loans and taxation:

1. The AMA-MSS supports actively lobbying for legislation aimed at establishing an affordable student loan structure with a variable interest capped at no more than 5.0%.
2. The AMA-MSS supports and will ask the AMA to support government-sponsored in-school loan interest subsidies should be maintained.
3. The AMA-MSS will ask the AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate.
4. The AMA-MSS will ask the AMA to lobby for passage of legislation that would (1) eliminate the cap on the student loan interest deduction, (2) increase the income limits for taking the interest deduction, (3) an increase to annual and aggregate loan limits to better reflect the true cost of medical education at the student applicant’s medical school, (4) include room and board expenses in the definition of tax-exempt scholarship income.
5. The AMA-MSS will ask the AMA to support legislation that does not require medical students attending school full-time twelve months per year to provide summer earnings allowances as partial fulfillment of their loan requirements.
6. The AMA-MSS will ask the AMA to lobby for passage of legislation that would make permanent the education tax incentives that our AMA successfully lobbied for as part of the Economic Growth and Tax Relief Reconciliation Act of 2001.
7. The AMA-MSS will ask the AMA to oppose legislation that would allow medical school scholarships or fellowships to be subject to federal income or social security taxes (FICA).
8. The AMA-MSS will encourage members to write letters to senators and representatives, especially those on the appropriate specific subcommittees, to support the visitation of the issue of how interest rates on student loans are determined and will provide a sample letter of support for this cause to AMA-MSS members so that members can simply sign and forward the letter to their respective governmental representatives.

(MSS GC Rep A, I-17)

305.086MSS Medical Student Dependent and Spousal Care: The AMA-MSS supports the following principles regarding the care of medical school students’ spouses and dependents:
1. That the AMA-MSS will ask the AMA to pursue legislation to change the cost of attendance definition to include costs for food, shelter, clothing, healthcare, and dependent care for all dependents.

2. That the AMA-MSS supports and will ask the AMA to work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent, spousal and same-sex spousal equivalent health insurance, dependent care, and dependent living expenses be included both as part of the “cost of attendance” and as an educational expense in medical student financial aid budgets.

3. That the AMA-MS as its Council on Medical Education, Academic Physician Section and Women Physician Section to consider alternative methods to carry out the intentions of current HOD policy on the issue of dependent health insurance, dependent care, and dependent living expenses.

4. The AMA-MSS supports and will ask the AMA to support the Parent Loan Program and its expansion so that parents and spouses of medical students can borrow at less than market rates.

(MSS GC Rep A, I-17)

305.087MSS Voluntary Service-Payback and Loan Repayment Programs: The AMA-MSS supports the following principles regarding voluntary service-payback and loan repayment programs:

1. The AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas.

2. The AMA-MSS will ask the AMA to advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program.

(MSS GC Rep A, I-17)

305.088MSS Increasing Availability and Access to Financial Aid: The AMA-MSS supports the following principles regarding access to student loans and availability of financial aid and scholarship monies:

1. That the AMA-MSS will ask the AMA to ask state medical societies to develop and implement interest-subsidized guaranteed student loan programs via the private sector in order to maintain a choice of funding to students.

2. That the AMA-MSS will ask the AMA to recommend that state medical societies raise funds for such programs by physician contributions over a short, but definite, term.

3. That the AMA-MSS will ask the AMA to work with state medical societies, associated foundations and medical schools to ensure that information about all offered scholarships is readily available online.

4. That the AMA-MSS will ask the AMA to encourage societies to support further expansion of state loan repayment programs, and, expansion of those programs to cover physicians in non-primary care specialties.

5. That the AMA-MS will ask the AMA to urge each state medical society strongly to add a voting medical student representative to its foundation Board of Directors or other appropriate governing body in addition to collecting and propagating bylaw changes from state societies that have added a medical student vote to their Board of Directors.

6. That the AMA-MSS will ask the AMA to urge, via its component state medical societies, all state foundations to consider converting any loan programs they may have into scholarship programs and provide information to said foundations on how other states have achieved this conversion.
7. That the AMA-MSS will ask the AMA to request that the state foundations and the AMA Foundation encourage donors to pool their funds with others to endow large scholarships.

8. That the AMA-MSS will ask the AMA to request that the AMA Foundation work with state medical societies and their foundations to (1) make scholarship programs direct-application at the medical school level, (2) ensure that scholarship funds are disbursed directly to the student, not to the medical school.

9. That the AMA-MSS will ask the AMA to request that the AMA Foundation compile and distribute to the state foundations a list of fundraising “best practices” that have been shown to be effective in raising funds for medical scholarships.

(MSS GC Rep A, I-17)

305.089MSS Medical Student Debt Management Education: The AMA-MSS supports the following principles regarding financial management and debt education of medical students:

1. That the AMA-MSS will ask the AMA to encourage medical school financial aid offices to educate medical students in medical debt management and provide financial and tax counseling.

2. That the AMA-MSS will ask the AMA to assist medical school financial aid offices in implementing debt management, financial, and tax counseling and education services.

3. That the AMA-MSS will encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.

4. That the AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants.

5. That the AMA-MSS ask the Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical colleges to provide additional data to students and applicants including by not limited to: (1) average debt incurred in medical school for graduation students with federal aid assistance, separated by in-state and out-of-state students, reported in quartiles, (1) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest-free loans, or grants available from the institution.

(MSS GC Rep A, I-17)

305.090MSS Medical Student Loan Forgiveness: The AMA-MSS supports the following principles regarding student loan forgiveness:

1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students.

2. That the AMA-MSS will ask the AMA to oppose the reduction and support that expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness.

3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including, but not limited to, the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency.

(MSS GC Rep A, I-17)

305.091MSS Understanding Philanthropic Efforts to Address the Rise of Medical School Tuition: AMA-MSS will 1) continue to study this topic to gain a better understanding of the sustainability of free and reduced medical tuition programs and of the efficacy of these programs in effecting medical specialty choice; and 2) regularly track the tuition reimbursement programs across medical schools to monitor outcomes. (MSS COLRP/CME Rep A, A-19)
The Residency Match Process: The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports to following principles to help improve the residency match process: 1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents. 2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. 3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately. 4. That the AMA-MSS supports a change in the NBME policy to report examination scores as “pass-fail” only. 5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution. 6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students' budgeting constraints. 7. That the AMA-MSS will ask theAMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels. 8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual’s ability to participate in residency training and required military or foreign service duty. 9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match. 10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional “Match Day” date in mid-March. (MSS GC Rep A, I-16).

Maternity Leave Benefits for House Staff: AMA-MSS will ask the AMA to support greater flexibility in residency training programs for maternity leave and alternative residency training schedules for pregnant house staff. (AMA Amended Res 89, I-79, Adopted [420.996])

MSS Graduate Medical Education Financing: 1. The AMA-MSS joins the AMA in its strong opposition to the reduction of Medicare Funding of graduate medical education and will advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions. 2. The AMA-MSS joins the AMA in its position that all payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding through, for example, expansion of government grant opportunities. 3. The AMA-MSS will ask the AMA to work together with other stakeholders to actively lobby Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid graduate medical education payments. 4. The AMA-MSS urges the AMA to work toward the removal of caps on residency programs funded by the Center for Medicare and Medicaid Services (CMS), and encourage the CMS to adjust Graduate Medical Education funding to account for the need of an expanded workforce. 5. The AMA-MSS supports the AMA (a) with consultation of
interested stakeholders, developing a comprehensive framework for a sustainable graduate medical education financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; (b) advocating for pilot projects supported through state and/or federal funding in medically underserved areas that foster resident training programs and offer loan repayment as a means to address the physician workforce shortage; and (c) working with our state medical societies for the drafting and implementation of model legislation to enact a comprehensive plan for graduate medical education reform once such a plan is developed. 6. The AMA-MSS supports combining Indirect Graduate Medical Education into the Direct Graduate Medical Education payments into a single, transparent funding stream. 7. The AMA-MSS support that Medicare’s Graduate Medical Education funding be a per-resident federal allocation that is adjusted according to solely geographic measures, such as cost-of-living. 8. The AMA-MSS will advocate for transparency in how graduate medical education funds are allocated to residency programs and for how those programs use the allotted funding. 9. The AMA-MSS support that the payment of Graduate Medical Education funding being directed to the designated residency GME Office, in lieu of the hospital system, to be allocated across the department(s), sites and other specialties to provide comprehensive training. 10. The AMA-MSS will publicize in an appropriate manner, to all medical students, the potential for the elimination or reduction of Medicare Funding of graduate medical education and the consequential development of uncompensated residency positions. 11. The AMA-MSS opposes further expansion of graduate medical education funding to non-physician “residencies” at the expense of Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 12. The AMA-MSS supports legislation regarding new funding for primary care graduate medical education designated for Accreditation Council for Graduate Medical Education- or AOA Commission on Osteopathic College Accreditation-accredited residency programs. 13. The AMA-MSS supports direct graduate medical education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification, in order to ensure flexibility of career choice. (GC Rep A, I-16)

310.004MSS Shared Residencies: AMA-MSS will ask the AMA to: (1) support residency programs that currently offer shared residencies; and (2) encourage the establishment of such programs nationwide.  (AMA Res 81, I-84, Adopted [H-310.990]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

310.006MSS The Influence of Residency Training on Quality of Patient Care in Teaching Hospitals: AMA-MSS supports the following principles: (1) There is a relationship between the structure and environment of residency training programs and the quality of patient care. (2) Quality of care is maximized in an intense training environment which recognizes human limitations inherent in all physicians and provides supportive mechanisms. (3) Compassion is an essential component to the provision of effective patient care. (4) To the extent that the residency training environment effects patient care, the medical profession should promote those components which facilitate desirable clinical outcomes. (MSS Rep I, I-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)


310.020MSS Restrictive Covenants in Training Programs: AMA-MSS strongly supports the removal of restrictive covenants from residency and fellowship programs.  (MSS Sub Res 33, A-97)


Resident Work Hours: (1) AMA-MSS will work with the AMA-RFS to make the improvement of hospital working conditions, including resident/fellow work hours, a top priority for the AMA. (2) AMA-MSS supports the concept of pursuing avenues in addition to working with the ACGME to alleviate resident work hour concerns. (MSS Late Res 2, A-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Report D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Resident/Fellow Work and Learning Environment: AMA-MSS supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-week period; (3) Trainees must be scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important to patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) The Joint Commission should create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) The Joint Commission should establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; (11) The AMA Council on Legislation should serve as the coordinating body in the creation of legislative and regulatory options. (MSS Rep F, A-02) (AMA Amended Res 310, I-01 Adopted [D-310.990, H-310.928]) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)
310.031MSS  Resident/Fellow Work and Learning Environment: (1) AMA-MSS will ask the AMA to continue to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation; (2) AMA-MSS will (a) continue to work, along with AMA-RFS, with groups such as the Committee of Interns (CIR) on collaborative efforts to see that duty hour reform is enforced and (b) continue to work to improve working conditions for residents and fellows. (MSS Rep D, A-03) (AMA Amended Res 322, A-03 Adopted; Resolve 8, Referred) (Amended: MSS Rep E, I-08) (Modified: GC Rep B, I-13)

310.033MSS  Eliminating Religious Discrimination from Residency Programs: AMA-MSS will ask the AMA to: (1) encourage the adoption of residency requirements that allow individuals to honor their religious beliefs and practices; (2) encourage the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to extend its current policies regarding religious exceptions to include the observance of religious holidays and observances; (3) encourage the Accreditation Council for Graduate Medical Education to require that all residency programs become aware of and make an effort to ensure that residents be allowed to practice in a manner that does not interfere with their religious convictions, including observance of religious holidays and observances. (MSS Rep E, A-04) (AMA Res 308, A-05 Referred) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

310.034MSS  Compensation for Resident/Fellow Physicians: The AMA-MSS recognizes the tremendous value of GME for patients and supports systems wherein adequate compensation is provided during GME training and supports the following principles regarding resident/fellow compensation: 1. The AMA-MSS supports reforming the current system of determining residents’ salaries so that a resident’s level of training, cost of living, whether or not they work in an underserved area, and other factors relevant to appropriate compensation of residents are taken into account. 2. The AMA-MSS asks that our AMA (a) work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians reflect the unique and extensive amount of education and experience acquired by physicians; (b) study the use of collective bargaining with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (c) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians. (MSS GC Rep A, I-16)

310.039MSS  Opposition to Protected Sleep Time: AMA-MSS will ask the AMA to (a) support additional study of the issues raised with respect to duty hours in the 2008 Institute of Medicine report, Resident Duty Hours: Enhancing Sleep, Supervision, and Safety, and consider further modifications of the current duty hours requirements based on the results of this inquiry; and (b) support the evaluation and improvement of duty hours reform that does not include protected sleep time. (MSS Amended Res 3, A-09) (AMA Res 303, A-09 Referred) (Modified and Reaffirmed: MSS GC Rep A, I-14)

310.041MSS  Improving Primary Care Residency Training to Advance Health Care for Gay, Lesbian, Bisexual, and Transgender Patients: AMA-MSS will ask the AMA to work with the Accreditation Council for Graduate Medical Education and the American Osteopathic Association to recommend to primary care residency programs that they assess the adequacy and effectiveness of their curricula in training residents on best practices for caring for gay, lesbian, bisexual, and transgender (GLBT) pediatric patients. (MSS Res 11, A-10) (AMA policy H-295.878 Amended in Lieu of AMA Res 906, I-10) (Reaffirmed, MSS GC Rep D, I-15)
310.042MSS  Medical Student Position Regarding the 2010 ACGME Residency Work Standards: AMA-MSS: (1) supports programs focused on improving patient care with clear and measurable outcomes while paying equal attention to other initiatives that have been shown to minimize preventable medical errors and that the decision of whether to impose additional limitations on medical student, resident and fellow duty hours should be based on the prevailing evidence; (2) supports additional efforts to improve patient safety outside of limiting medical student, resident, and fellow work hours, including more adequate training in the art of transitioning care and identification of limitations due to sleep deprivation; and (3) supports supervision of medical students, residents and fellows that allows for competency based independence and delegation of clinical responsibility appropriate for level of training. (MSS Res 15, I-10) (Reaffirmed: MSS GC Rep D, I-15)

310.046MSS  Investigating Adverse Public Health Outcomes Relating to Chronic GME Funding Shortages: AMA-MSS will ask the AMA to act to encourage appropriate stakeholder organizations to study and quantify the public health impacts of cuts to GME funding sources, including the effects on, but not limited to, the physician shortage, spending on public health initiatives, and availability and quality of care. (MSS Res 6, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 303, A-12) (Reaffirmed: MSS GC Report A, I-16)

310.048MSS  Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies: AMA-MSS supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy. (Late Res 2, A-13)

310.049MSS  Equal Paternal and Maternal Leave for Medical Residents: That our AMA amend policy H-405.960 by insertion and deletion as follows:

H-405.960 Policies for Maternity, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity, Family and Medical Necessity Leave for Medical Students and Physicians: (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement; (2) Recommended components of maternity and paternity leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed, and (i) leave policy for adoption; and (j) leave policy for paternity. (3) AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking maternity and paternity leave without the loss of status. (4) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity and paternity leave policies a six-week minimum leave allowance, with the understanding that no woman or man should be required
to take a minimum leave; (5) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (6) Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (7) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provisions are made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (8) Our AMA endorses the concept of paternity leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice equal to maternity leave benefits; (9) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (10) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; (11) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility; (12) Our AMA encourages flexibility in residency training programs, incorporating maternity and paternity leave and alternative schedules for pregnant house staff; and (13) In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year; and (14) These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.


310.050MSS Addressing the Increasing Number of Unmatched Medical Students: AMA-MSS will ask that the AMA (1) study, in collaboration with the Association of American Medical Colleges (AAMC) and the American Osteopathic Association (AOA), the common reasons for failures to match; and (2) study potential pathways for reengagement in the medical field for applicants to the National Resident Matching Program (NRMP) who fail to match. (MSS Res 3, I-14)

310.051MSS Standardizing the Residency Match System and Timeline: That our AMA-MSS study the reasons for ophthalmology and urology residencies using the non-NRMP match systems including reasons for non-participation in NRMP match system, and that our MSS report its findings by Interim 2015. (MSS Sub Res 1, A-15)
Preventing Resident Physician Suicide: AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

Improving Support and Assistance for Medical Students with Disabilities: AMA-MSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM). (MSS Res 33, A-18)

Medical Records

Patient Confidentiality and Government Investigations: AMA-MSS opposes the implementation of federal legislation that would enable any government agency or representative of such agency to access a patient’s medical records without the patient’s knowledge and consent or court order. (MSS Amended Sub Res 11, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Privacy of Student Electronic Medical Records at Medical School Affiliated Hospitals: AMA-MSS supports added safeguards, such as audits or “break the glass” access, for medical student records when those records are placed in the same system used for patients at the school’s affiliated hospitals. (MSS Res 13, I-12) (Reaffirmed: MSS GC Report A, I-17)

Enabling a Contiguous, National Electronic Health Record Network: AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13)

Implementing the Use of EHR in Jail Health Services: AMA-MSS will ask the AMA to study the prevalence of and barriers to electronic health record utilization within corrections facilities. (MSS Res 35, A-15) (Existing AMA Policies Reaffirmed In Lieu of AMA Res 805, I-15)

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation: AMA-MSS will ask (1) that our AMA support the inclusion of a patient’s biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive manner; and (2) that our AMA advocate for collection of patient data that is inclusive of sexual
orientation/gender identity for the purposes of research into patient health. (MSS Res 09, A-16)

315.006MSS Improving Cybersecurity in Healthcare Facilities: AMA-MSS supports the development of new cybersecurity resources for providers that go beyond HIPAA compliance in order to adequately protect patient health information against new cybersecurity threats, such as ransomware, as they emerge. (MSS Res 07, I-16)

315.007MSS Integration of Drug Price Information Into Electronic Medical Records: Our AMA-MSS will ask the AMA to (1) support the incorporation of estimated patient out of pocket drug costs into electronic medical records in order to help reduce patient cost burden; and (2) collaborate with invested stakeholders, such as physician groups, Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to integrate estimated out of pocket drug costs into electronic medical records in order to help reduce patient cost burden. (MSS Res 01, I-16) (AMA Res 219, A-17 Referred)

325.000MSS Medical Societies


345.000MSS Mental Health

345.001MSS De-institutionalization of Mental Patients: AMA-MSS will ask the AMA to: (1) support the concept that the de-institutionalization of former psychiatric patients should be accompanied by adequate support from the community in the form of rehabilitation and counseling services; and (2) affirm the basic human rights of patients in board and care facilities to receive proper nutrition, essential medical care, adequate housing, community support, and to be permitted to participate in decisions regarding their environment. (AMA Res 160 A-79 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

345.002MSS An Initiative to Encourage Mental Health Education in Public Schools and Reducing Stigma and Increasing Detection of Mental Illnesses: AMA-MSS will ask the AMA to: (1) work with mental health organizations to encourage patients to discuss mental health concerns with their physicians; and (2) work with the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for elementary through high school students. (MSS Sub Res 22, I-05 Adopted in Lieu of Res 12 and 13) (AMA Amended Res 412, A-06 Adopted [H-345.984]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

345.003MSS Improving Pediatric Mental Health Screening: AMA-MSS will ask the AMA to (1) recognize the importance of, and support the inclusion of, mental health screening in routine pediatric physicals; and (2) work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health concerns in primary care settings. (MSS Res 29, A-10) (AMA Res 414, A-11 Adopted as Amended [H-345.977]) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep D, I-15)
345.004MSS

Stigmatization of Mental Health Disorders within the Medical Profession: AMA-MSS will ask the AMA to address the stigmatization of mental health disorders in medical professionals by medical professionals by taking an active role in activities such as developing and/or encouraging programming to promote awareness about and reduce this stigmatization. (MSS Res 37, A-11) (Modified: MSS GC Report A, I-16)

345.006MSS

Reduced Incarceration and Improved Treatment of Individuals with Mental Illness or Illicit Drug Dependence: AMA-MSS will ask the AMA to amend policy H-430.989 by insertion and deletion as follows:

H-430.989 Disease Prevention and Health Promotion in Correctional Institutions

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward 1. the prevention and control of HIV/AIDS, substance abuse, tuberculosis and hepatitis, 2. the management and treatment of psychiatric disorders such as drug dependence, and 3. a reduction in reincarceration rates related to drug abuse and psychiatric disorders. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers, and drug treatment center staff, and psychiatric care center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs, as well as inpatient or outpatient psychiatric treatment programs, as a sentence or in connection with sentencing."


345.007MSS

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications: AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards’ practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician’s private health record confidentiality by requiring access to these records when an applicant reports treatment. (MSS Res 17, I-13)

Improving the Intersection Between Law Enforcement and the Mentally Ill: AMA-MSS recognizes Crisis Intervention Team (CIT) training as an effective tool for 1) educating law enforcement officers about the mentally ill, 2) diverting mentally ill offenders from jails and prisons to medical treatment centers, and 3) developing a more judicious use-of-force by law enforcement in encounters with patients in mental health crises; and supports the National Mental Health Alliance and other national and local mental health organizations to advocate for the development and nationwide implementation of training programs, such as CIT, that are designed to improve law enforcement’s responses to the mentally ill. (MSS Res 5, A-15)

345.008MSS

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools: AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)
Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel: AMA-MSS will ask (1) that our AMA support efforts to decriminalize suicide attempts in the military and (2) that our AMA support efforts to provide treatment for survivors of suicide attempt in lieu of punishment in the military. (MSS Res 26, A-16) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 001, I-16)

Improving Mental Health at Colleges and Universities for Undergraduates: AMA-MSS will ask (1) that our AMA support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need; (2) that our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources; and (3) that our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. (MSS Res 30, A-16)

Addressing Medical Student Mental Health Through Data Collection and Screening: AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A-17 Adopted as Amended [appended to H-295.858])

Studying the Effectiveness of Telemental Health in Schools: AMA-MSS supports research by appropriate stakeholders assessing the effectiveness of telemental health programs in comparison to standard mental health services offered by elementary, middle, and secondary educational institutions. (MSS Res 20, I-16)

Co-Location of Behavioral Health Care and Primary Care: AMA-MSS supports the co-location of behavioral health services within primary care clinics and other locations where primary care services are provided. (MSS Res 11, A-17)

Addressing Social Media Usage and its Negative Impacts on Mental Health: AMA-MSS will ask that our AMA (1) collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians’ knowledge of the health impacts of social media usage, and (b) to develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage; and (2) advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage. (MSS Res 41, A-17)

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness: AMA-MSS will ask the AMA to (1) oppose restrictive housing for incarcerated persons with mental illness and (2) encourage appropriate stakeholders to continue to develop and implement alternatives to restrictive housing for incarcerated persons with mental illness in all correctional facilities. (MSS Res 04, I-17)

Support Mental Health Screenings for Detained Minority Youth: (1) AMA-MSS supports equal and appropriate mental health referrals in the detained minority youth population; (2) AMA-MSS advocates for nondiscriminatory mental health screenings for all juvenile delinquents prior to admission; and (3) AMA-MSS supports focused funding on research and regular evaluations to decrease disparities in mental health screening protocols at juvenile detention centers. (MSS Res 39, A-18)
Support for the Use of Psychiatric Advance Directives: AMA-MSS will ask the AMA to support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (MSS Res 04, A-19)

Support for Veterans Courts: AMA-MSS will ask the AMA to support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (MSS Res 24, A-19)

Limiting the Use of Restrictive Housing in Adult Correctional Facilities: AMA-MSS will: (1) oppose the use of restrictive housing in adult correctional facilities for disciplinary purposes or pending investigation of a suspected rule violation for more than 15 consecutive days; (2) support efforts to ensure that the mental and physical health of all individuals in restrictive housing are regularly monitored by health professionals; and (3) support the development and use of safe alternatives to restrictive housing in adult correctional facilities. (MSS Res 26, A-18)

Minorities

Minority and Disadvantaged Medical Student Recruitment and Retention Programs: AMA-MSS will ask the AMA to encourage medical schools to continue and/or develop programs to expose economically disadvantaged students to the career of medicine; special summer programs to bring minority and economically disadvantaged students to medical schools for an intensive exposure to medicine; and conduct retention programs for minority and economically disadvantaged medical students who may need assistance. (AMA Res 35, I-79 Referred) (CME Rep T, I-79, Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS Res 4, I-14) (Reaffirmed: MSS Res 27, I-15) (Reaffirmed: MSS Res 19, I-17)


Continued Support for Diversity in Medical Education: AMA-MSS publicly states and reaffirms and will ask the AMA to publicly state and reaffirm its stance on diversity in medical education and its strong opposition to the reduction of opportunities used to increase the

350.012MSS Opposing Legislation to Cut Funding to the HRSA Health Careers Opportunity Program and the HRSA Centers of Excellence Program: AMA-MSS will ask the AMA to: (1) publicly oppose any reduction or elimination of funding for the Health Careers Opportunity Program and the Centers of Excellence Program; and (2) work with other interested organizations to seek increased public and private sector funding for the Health Careers Opportunity Program and the Centers of Excellence Program. (MSS Res Late 2, I-06) (Amended CME Rep 1 Adopted in Lieu of AMA Res 830, I-06 [D-200.985]) (Reaffirmed: MSS GC Report D, I-11) (Reaffirmed: MSS GC Report A, I-16)

350.013MSS Psychiatric Diseases Among Ethnic-Minority and Immigrant Populations: AMA-MSS will ask the AMA to encourage the National Institutes for Mental Health (NIMH) and local health departments to examine national and regional variations in psychiatric illnesses among immigrant and minority populations with the goal of creating psychometrically validated tools to appropriately address the needs of immigrant and minority populations. (Sub MSS Res 25, A-12) (Reaffirmed: MSS GC Report A, I-17)

350.014MSS Youth Health Pipeline Programs Initiative: AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with local medical societies to develop pipeline programs that increase underrepresented in medicine (UIM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical school AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students. (MSS Res 27, I-15)

350.015MSS Patient and Physician Rights Regarding Immigration Status: AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal) (AMA Res 018, A-17 Adopted [H-315.966])

350.016MSS Improving Medical Care in Immigration Detention Centers: AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigration and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

350.017MSS Disaggregation of Data Concerning the Status of Asian-Americans: AMA-MSS will ask that our AMA support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (MSS Res 27, A-17)
350.018MSS  Defense of Affirmative Action: AMA-MSS will ask the AMA to oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. (MSS Res 38-I-17, HOD Res 207 I-18 Adopted)

350.019MSS  Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level: AMA-MSS will (1) support the collaboration between local chapters and allied medical student organizations, including but not limited to Student National Medical Association, Latino Medical Student Association, and Asian Pacific American Medical Student Association, in order to increase underrepresented minority medical student participation in the AMA-MSS, and (2) support regional leadership in promoting Local Chapter creation of a Minority Liaison executive committee position aimed at increasing collaboration between the AMA-MSS and minority student organizations. (MSS Res 19, A-19)

350.020MSS  Accurate Collection of Preferred Language and Disaggregated Race & Ethnicity to Characterize Health Disparities: AMA-MSS will ask the AMA to 1) amend H-315.996 by insertion to read as follows:

Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records H-315.996

The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient.; and

2) encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.

(MSS Res 29, A-19)

350.021MSS  Addressing the Racial Pay Gap in Medicine: AMA-MSS will ask the AMA to (1) support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment; and (2) support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries of race and medical physicians. (MSS Res 42, A-19)

350.022MSS  Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities: AMA-MSS will ask the AMA to (1) advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations; (2) work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourage healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) oppose the presence of U.S. Immigrations and Customs Enforcement (ICE) at healthcare facilities. (MSS Res 43, I-17) (AMA Res 232, I-17, Adopted [D-160.921])

360.000MSS  Nurses and Nursing
**AMA-MSS Digest of Policy Actions**

**360.001MSS**

**Increasing the School Nurse to Student Ratio:** AMA-MSS will ask the AMA to (1) encourage state medical societies and organizations, such as the National Association of School Nurses and other stakeholders, to advocate at all levels for adequate funding of school nurse positions; and (2) encourage public schools, private schools, and other relevant organizations to employ school nurses in a manner that complies with CDC recommended nurse-to-student ratios. (MSS Res 23, A-12) (Reaffirmed: MSS GC Report A, I-17)

**360.002MSS**

**Increasing Patient Access to Sexual Assault Nurse Examiners:** AMA-MSS will ask the AMA to advocate for increased patient access to Sexual Assault Nurse Examiners in the Emergency Department, including the transfer of victims to other facilities with Sexual Assault Nurse Examiners when they are not available. (MSS Res 12, A-18)

**365.000MSS**

**Occupational Health**

**365.001MSS**

**Regulation of Occupational Carcinogens:** AMA-MSS will ask the AMA to: (1) endorse the principle of using the best available scientific data including animal models as a basis for regulation of occupational carcinogens; and (2) urge OSHA to reinstate its regulation of carcinogens on the basis of best available scientific data including animal studies. (Sub AMA Res 81, I-82 Adopted [H-365.996]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**365.002MSS**

**Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers:** AMA-MSS will ask the AMA to: (1) encourage OSHA to adopt industry-wide standards which guarantee a health care worker’s right to confidentiality, appropriate counseling, and treatment following the positive conversion of a tuberculosis PPD skin test; and (2) encourage OSHA to adopt industry-wide standards that guarantee that all prospective health care workers have a right to confidentiality, appropriate counseling, and treatment referral following a positive tuberculosis PPD skin test, which was obtained as a result of a pre-employment physical examination. (MSS Sub Res 5, I-96) (AMA Sub Res 210, A-97 Adopted [H-440.905]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

**365.003MSS**

**On-Site Employer Medical Clinics:** AMA-MSS will ask the AMA to develop guidelines for the operation of on-site employer-sponsored medical clinics, ensuring that employee privacy, safety, and access to preventive health are not compromised. (Sub MSS Res 26, I-11) (AMA Res 103, A-12 Adopted as Amended [D-160.937]) (D-160.937 Rescinded: CMS Rep 1, A-13) (Modified: MSS GC Report A, I-16)

**Hospital Workplace and Patient Safety and Weapons:** (1) AMA-MSS supports policies which restrict guns and Tasers in civilian healthcare delivery settings and (2) AMA-MSS supports comprehensive training of security personnel that focus on patient safety and empathy. (MSS Late Res 01, A-16)

**365.004MSS**

**Reimbursement for Post-Exposure Protocol for Needlestick Injuries:** AMA-MSS will ask the AMA to (1) encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state’s workers’ compensation, where applicable; and (2) encourage state societies to work with their respective workers’ compensation program to include medical students as recipients of medical benefits in the event of blood or body substance exposure sustained during clinical rotations. (MSS Res 11, A-19)
370.000MSS  Organ Donation and Transplantation

370.003MSS  Organ Donors and Transplants: AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep Z, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12) (Reaffirmed: MSS GC Report A, I-17)

370.005MSS  Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors: AMA-MSS will ask the AMA to support efforts to increase the number of all potential bone marrow donors, especially minority donors, registered in national bone marrow registries to improve the odds of successful HLA matching and bone marrow transplantation. (AMA Res 501, I-94 Adopted [H-370.974]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

370.010MSS  Increasing Organ Donation Discussions through Medical Education: Our AMA-MSS will (1) encourage the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and the Liaison Committee on Medical Education to include training on organ donation discussions in undergraduate and graduate medical education; (2) ask the AMA to compile current materials into a comprehensive resource and make them available for the development of a Continuing Medical Education Activity educating physicians on how to conduct organ donation discussions with patients; and (3) ask the AMA to support the development of billing codes for physician-patient organ donation discussions. (MSS Res 9, I-11) (AMA Res 307, A-12 Not Adopted) (Reaffirmed: MSS GC Report A, I-16)

370.011MSS  Investigating the Possibility of a Unified Living Donor Kidney Registry: AMA-MSS will encourage the AMA to support the study of how to develop a unified, nationwide living kidney donor registry and advocate for public and private funding of such studies to reach the long term goal of establishing a unified registry. (MSS Res 24, I-12) (AMA Res 2, A-13 Referred for Decision) (Reaffirmed: MSS GC Report A, I-17)

370.012MSS  Organ Donation Education Programs in Driver Training Programs: AMA-MSS will ask the AMA to encourage all states to include organ and tissue donation education in pre-licensing and drivers training programs. (MSS Res 29, I-12) (Policy H-370.984 Adopted as Amended in Lieu of AMA Res 3, A-13) (Reaffirmed: MSS GC Report A, I-17)

370.013MSS  Presumed Consent Organ Donation: AMA-MSS will ask the AMA to reexamine the ethical considerations of presumed consent and other potential models for increasing the United States organ donor pool. (MSS Res 1, I-13)

370.014MSS  Removal of Cannabis as a Relative Contraindication for Potential Organ Transplant: AMA-MSS opposes utilization of 1) reported marijuana use; and 2) positive cannabis toxicology tests as a relative contraindication for potential organ transplant recipients. (MSS Late Res 3, I-14)

370.015MSS  Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool: AMA-MSS will ask (1) that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation, (2) that our AMA support well-designed studies investigating the use of incentives,
including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (MSS Res 08, I-15 Immediate Transmittal to HOD) (AMA Res 007, I-15 Adopted)

**370.016MSS**  
**Targeted Education to Increase Organ Donation:** AMA-MSS will ask that our AMA study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates. (MSS Res 18, I-15) (AMA Res 004, A-16 Adopted)

**370.017MSS**  
**Living Organ Donation at the Time of Imminent Death:** AMA-MSS will ask (1) that our AMA study the implications of the removal of barriers to living organ donation at the time of imminent death. (MSS Res 24, A-16) (Existing AMA Policy Reaffirmed in Lieu of AMA Res 002, I-16)

**370.018MSS**  
**Protecting Equity in Access to Kidney Dialysis and Transplant and Advocating for Patients’ best Interest in End Stage Renal Disease:** AMA-MSS supports evidence-based patient education and counseling regarding the relative risks and benefits of all treatment options for end-stage renal disease, including various types of dialysis and organ transplantation. (MSS Res 6, I-17)

**370.019MSS**  
**Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease:** AMA-MSS supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol-related liver disease. (MSS Res 08, A-18)

**370.020MSS**  
**Improving Body Donation Regulation:** AMA-MSS will ask the AMA to recognize the need for ethical, transparent, and consistent body and body part donation regulations. (MSS Res 11, I-18) (AMA Res 12 A-19, Adopted [H-460.890])

**385.000MSS**  
**Physician Payment**

**385.001MSS**  

**385.002MSS**  
**The Patient-Centered Medical Home Concept:** AMA-MSS will ask the AMA to (1) Adopt the following definition of the patient-centered medical home model as set forth by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association in the Joint Principles of the Patient-Centered Medical Home:

(a) Personal physician  
(b) Physician directed medical practice  
(c) Whole person orientation  
(d) Care is coordinated and/or integrated  
(e) Quality and safety  
(f) Enhanced access  
(g) Payment;

(2) Continue to support the Medicare Medical Home Demonstration project and study the implications of including “payment” as a principle in the definition of the patient-centered medical home model; and (3) Advocate that every American have access to medical services

390.000MSS  **Physician Payment: Medicare**

390.001MSS  **Mandatory Assignment:** AMA-MSS opposes mandatory assignment or any other pressure to accept claims on a assigned basis under Medicare in appropriate forums within the AMA. (MSS Rep I, I-84) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

390.004MSS  **Reimbursement Violations:** AMA-MSS will ask the AMA to urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution. (AMA Sub Res 705, A-93 Adopted [H-335.973]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

390.005MSS  **Opposing Medicare Reimbursement Based Off of Patient Satisfaction Score:** Our AMA-MSS will ask that our AMA study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement. (MSS Res 10, A-16).

405.000MSS  **Physicians**

405.002MSS  **National Service Project:** (1) AMA-MSS recognizes the value of associating the AMA-MSS with a community service project at each medical school. (2) AMA-MSS will make available a national service project that may be implemented at each medical school. (MSS Res 17, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

405.005MSS  **Recognition for Community Service:** AMA-MSS will continue to encourage medical student community service through policy promotion grants and other available means. (MSS Rep H, I-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

405.006MSS  **Non-Compete Clauses in Physician Contracts:** AMA-MSS opposes the use of restrictive covenants in physician contacts and supports the passage of laws that prohibit their use. (MSS Res 56-I-17)

420.000MSS  **Pregnancy**

420.002MSS  **Substance Abuse During Pregnancy:** AMA-MSS will ask the AMA to: (1) continue its ongoing efforts to educate the general public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal development and expand these efforts to target abuse of other substances; and (2) encourage intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities. (AMA Res 244, A-89 Adopted [H-420.976]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)
420.003MSS Nutrition Counseling for Pregnant and Recent Post-Partum Patients: AMA-MSS will ask the AMA to (1) support physician referrals of pregnant and recent post-partum patients to registered dietitians for nutrition counseling; and (2) advocate for the extension of health insurance coverage to registered dietitian visits for all pregnant and recent post-partum patients. (MSS Res 31, I-10) (AMA Res 409, A-11 Adopted as Amended) (Reaffirmed: MSS GC Rep D, I-15)

420.004MSS Improving Mental Health Services for Pregnant and Post-Partum Mothers: AMA-MSS will ask the AMA to (1) support improvements in current mental health services for women during pregnancy and postpartum; (2) support advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage from 6 weeks to 1 year postpartum; and (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum. (MSS Res 33, I-11) (AMA Res 102, A-12 Adopted as Amended [H-420.953]) (Reaffirmed: MSS GC Report A, I-16)

420.005MSS Inclusion of Folic Acid Supplements in the Supplemental Nutrition Program: AMA-MSS will ask the AMA to (1) support the addition of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs; and (2) work with United States Department of Agriculture and other appropriate organizations to encourage and procedurally facilitate the implementation of folic acid supplements in the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and other similarly aligned programs. (MSS Res 20, A-12) (Policy D-150.983, D-150.987, D-150.981, H-150.937, H-150.933, H-150.944, H-150.953, H-150.960, H-440.902 and D-440.954 Reaffirmed in Lieu of AMA Res 201, A-13) (Reaffirmed: MSS GC Report A, I-17)

420.006MSS High Rates of Cesarean Deliveries: AMA-MSS will ask the AMA to (1) support the American Congress of Obstetricians and Gynecologists’ 2013 opinion that recommended vaginal delivery instead of cesarean section in the absence of maternal or fetal indications; and (2) encourage appropriate agencies and organizations to study the indications for cesarean section in order to achieve a greater degree of standardization in their use. (MSS Res 10, I-13) (AMA Res 706, A-14 Not Adopted)

420.007MSS Providing Complete Maternity Care Under the Affordable Care Act: AMA-MSS will ask the AMA to advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents’ large group plans. (MSS Res 13, I-13) (AMA Res 101, A-14 Adopted [H-185.997])

420.008MSS Advance Directives During Pregnancy: That our AMA-MSS ask our AMA to (1) support that pregnant women with decision-making capacity have the same right to refusal of treatment through advanced directives as non-pregnant women; and (2) study the legality and ethics related to the circumstances under which restrictions and/or exclusions are applied to pregnant women’s advance directives. (MSS Res 25, A-14) (AMA Res 1, I-14 Referred)

420.009MSS Opposition to Government Funding of Crisis Pregnancy Centers: AMA-MSS opposes federal, state, and local funding for crisis pregnancy centers that distribute information that is contradictory to current published medical information. (MSS Res 42, I-16)

420.010MSS Infertility and Infertility Insurance Coverage: AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons. (MSS Res 24-I-17)
Improving Minors’ Access to Prenatal and Pregnancy-Related Care: Our AMA-MSS supports the right of the minor to consent health care services from the prenatal stage through delivery, including but not limited to consenting to an epidural, a cesarean section, and testing for chromosomal abnormalities in the fetus. (MSS Res 25, A-18)

Support for the Standardization of Care for Postpartum Hemorrhage: AMA-MSS supports the standardization of care, and establishment of formal protocols for the management of postpartum hemorrhage. (MSS Res 09, I-18)

Professional Liability

A No-Fault Professional Liability System: AMA-MSS will ask the AMA to encourage state-based demonstration projects of a no-fault medical professional liability system as the preferred mechanism for improving patient safety, efficiently compensating injured patients, and reducing the substantial costs of defensive medicine and litigation to our healthcare system.(MSS Res 28, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

U.S. Medical Liability Crisis and the Impact on Clinical Medical Education: AMA-MSS will ask the AMA to: (1) recognize that undergraduate and graduate medical education are impacted by the medical liability crisis; and (2) oppose medical liability insurance premiums based solely on preceptor or volunteer faculty status (MSS Res 5, A-04) (AMA Res 909, I-04) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

Error Disclosure and Physician Apologies: AMA-MSS supports (1) full disclosure of medical errors; and (2) legislation that allows a physician to make an expression of apology, regret, sympathy, commiseration, condolence, or compassion to a patient or a patient’s family without it constituting an admission of physician liability for any purpose. (MSS Res 6, A-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Liability Coverage for Medical Students Completing Extramural Electives: (1) AMA-MSS will (a) encourage the Association of American Medical Colleges to increase the utility of its Extramural Electives Compendium (EEC) by providing information regarding liability coverage requirements at all host institutions and by making this a searchable feature, and additionally that the AMA-MSS provide a link to the EEC on its Web site; and (b) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; and (2) AMA-MSS will ask the AMA to (a) take into account the appropriate minimum levels of student liability coverage when examining the issue of student debt, particularly when in conversations with the administrations of various medical schools; (b) examine whether or not students have been found partially accountable in recent malpractice suits, as well as the appropriateness of the amounts of medical student liability coverage required by medical schools with respect to the current medical professional liability insurance market; and (c) examine the propriety of schools requiring their own and visiting students to carry levels of medical liability coverage in excess of the minimum amounts mandated for physicians by state law. (MSS Rep C, A-08) (AMA Res 913 Referred) (Reaffirmed: GC Rep B, I-13)

Quantifying Medical Tort Reform: (1) AMA-MSS supports medical liability reform at the federal, state, and municipal levels including, but not limited to, non-economic damage caps, collateral source offset provisions, and the implementation of malpractice courts; (2) AMA-
MSS will ask the AMA to study the true costs of defensive medicine and the financial impact that tort reform would have on the entire health care system, with a report back and to be updated every ten years. (MSS Res 15, I-09) (AMA Res 216, I-09 Adopted [D-435.973]) (Reaffirmed: MSS GC Rep A, I-14)

440.000MSS  Public Health

440.001MSS  Qualifications of the Surgeon General: AMA-MSS will ask the AMA to: (1) endorse the concept that the Surgeon General of the United States should have substantial experience or training in public health; and (2) oppose any nominations for the position of U.S. Surgeon General of persons without such background. (AMA Res 154, A-81 Not Adopted (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.002MSS  Immunization Programs for Children: AMA-MSS will ask the AMA to: (1) support domestic and international immunization programs; (2) develop legislation to ensure the priority of these programs; and (3) urge more intensive research to develop improved vaccines and immunization technology. (AMA Amended Res 63, I-82 Adopted [H-440.991]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.003MSS  Childhood Immunization: AMA-MSS will ask the AMA to: (1) support legislation to assure a safe and adequate supply of childhood vaccines; and (2) impress upon Congress the urgency of the effects of decreasing numbers of vaccine manufacturers on the public health of the nation's children. (AMA Res 130, A-86 Adopted [H-60.969]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)


440.006MSS  Ocular Sun Damage to the Retina and its Prevention: AMA-MSS will ask the AMA to: (1) work with the Centers for Disease Control (CDC) to educate physicians and the public on the

**440.011MSS** Nosocomial Transmission of Disease via Stethoscope: AMA-MSS will ask the AMA to advocate that health care providers frequently clean their stethoscopes and take all reasonable precautions with their other hand-held instruments in order to minimize the potential risk of nosocomial infection. (AMA Res 501, I-96 Adopted [H-440.908]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)


**440.013MSS** Obesity as a Chronic Disease: AMA-MSS will ask the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence-based recommendations regarding education, prevention, and treatment of obesity. (MSS Amended Sub Res 33, A-98) (AMA Amended Res 423, A-98 Adopted [H-440.902]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS GC Report A, I-12)


**440.018MSS** Childhood Obesity as a Public Health Epidemic: AMA-MSS urges physicians to work with appropriate federal agencies, medical specialty societies, and public health organizations to overcome cultural, temporal, and economic barriers to exercise prescription by developing and demonstrating the effectiveness of culturally appropriate and necessary tools, including mass media based efforts, to help physicians more effectively counsel obese and overweight children and their families with special emphasis on targeting high risk groups. (MSS Sub Res 5, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

**440.019MSS** Requirement for Daily Free Play in Schools: AMA-MSS will ask the AMA to: (1) recommend that elementary schools maintain at least thirty minutes of daily free play during each school day; and (2) work with other interested medical societies to urge the Department of Education and state and national legislatures to enact regulatory and legislative provisions that ensure at least thirty minutes of daily free play for elementary school students. (MSS Res 20, I-03) (AMA Amended Res 409, A-04 Adopted [H-470.961 and D-470.994]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B-I-13)

**440.020MSS** Support for Needlestick Prevention: AMA-MSS strongly supports the implementation of needlestick prevention devices, including but not limited to retractable needles or needleless systems, with the participation of physicians and other health care workers who will use such
devices and, where appropriate, the introduction of such devices accompanied by the necessary education and training as part of a comprehensive sharps injury prevention and control program. (MSS Res 29, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

440.021MSS Promoting Fitness and Healthy Lifestyles: AMA-MSS encourage all physicians and health professionals to set an example by (1) striving to maintain a healthy weight and engaging in physical activity as recommended by scientific literature and expert panels; (2) maintaining a healthy and nutritious diet as recommended by scientific literature and expert panels; and (3) getting enough sleep to avoid the known short and long term adverse effects of sleep deprivation as recommended by scientific literature and expert panels. (MSS Res 28, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS Res 41, I-16) (Reaffirmed: MSS GC Report A, I-16)

440.022MSS U.S. Government Involvement in Preventing Future Vaccine Shortages: AMA-MSS will encourage the U.S. government to create a long-term solution to change the infrastructure of the vaccine industry to prevent future problems such as shortages. (MSS Res 29, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

440.023MSS Support for a National Center on Pain Research: AMA-MSS will ask the AMA to support the development of a Center or Institute for Pain Research that would assist in the distribution of funding toward more clinical and basic science research regarding the treatment as well as the biology of pain and support efforts to create public awareness on responsible pain management, symptom management, and palliative care. (MSS Sub Res 37, I-04) (AMA Res 513, A-05 Referred) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

440.024MSS Advertising for Herbal Supplements: AMA-MSS will and will ask the AMA to: (1) strongly encourage the naming of herbal supplements in a manner so that they cannot be confused with prescription drugs; (2) strongly discourage the advertising of herbal supplements in a way that resembles prescription drug advertisements; (3) work with the appropriate agencies to strengthen regulations regarding the advertising and distribution of herbal supplements and work with appropriate agencies to improve public awareness of regulations and distribution practices associated with herbal supplements, including but not limited to purity, safety, and pregnancy risk. (MSS Res 38, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

440.025MSS Increasing Access to Healthcare by Correcting Treatable Disturbances in Visual Acuity to Improve Public Health Outcomes: AMA-MSS will ask the AMA to: (1) encourage the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) support referring those seeking a driver's license who fail a vision screening at their respective Department of Motor Vehicles to an appropriate healthcare provider for a complete dilated eye exam and information about free health coverage programs when necessary or applicable. (MSS Res 16, A-05) (AMA Amended Res 813, I-05 Adopted [H-25.990]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.026MSS Urging the Establishment of a Federal Office of Men’s Health: AMA-MSS will ask the AMA to promote the establishment of a federal Office of Men’s Health to coordinate outreach and awareness efforts on the federal and state levels, promote preventive health behaviors for men, and provide a vehicle whereby researchers on men's health can collaborate and share information and findings. (MSS Res 18, A-05) (AMA Res 706, I-05 Not Adopted) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.027MSS Increasing Accessibility to Meningitis Protection: (1) AMA-MSS will encourage all universities to offer the meningococcal vaccine preferably at reduced cost and to educate
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students about the benefits of vaccination. (2) AMA-MSS supports the incorporation of the cost of the meningococcal vaccine into the estimated cost of attendance. (MSS Res 17, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

440.028MSS HPV Vaccine in Cervical Cancer Prevention Worldwide: AMA-MSS will ask the AMA to: (a) urge physicians to educate themselves and their patients about HPV vaccination; (b) encourage the development and funding of programs targeted at reducing HPV transmission and screening for infection and precancerous cervical changes in developing countries; (c) intensify efforts to improve awareness and understanding about the availability and efficacy of HPV vaccinations in the general public; (d) encourage the integration of HPV vaccination into reproductive health care settings, including but not limited to routine reproductive health care visits for adults and adolescents; and (e) support the availability of the HPV vaccine to patient groups that benefit most from preventative measures, including but not limited to low-income and pre-sexually active populations. (MSS Res 5, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

440.029MSS Usage of Alcohol Based Hand Sanitizers in Institutional Settings: AMA-MSS: (1) recognizes alcohol-based hand sanitizers with alcohol concentrations of greater than 60% as an effective adjunct to hand washing in reducing microbial contamination and spread; and (2) urges the placement of alcohol-based hand sanitizer dispensers in institutional settings and highly trafficked public areas. (MSS Res 9, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

440.032MSS Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance: AMA-MSS will ask the AMA to work with interested partners in the Federation of Medicine to develop formal recommendations, based on a review of the evidence and expert clinical judgment, to develop and/or improve new or existing FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial-resistant pathogens. (MSS Res 1, A-08) (AMA Res 530, A-08 Adopted as Amended [D-100.976]) (Reaffirmed: GC Rep B, I-13)

440.033MSS Placement of Alcohol-Based Hand Sanitizer Dispensers Outside of Public Restrooms: AMA-MSS will ask the AMA to (1) recognize alcohol-based hand sanitizers with alcohol concentrations greater than 60 percent as an effective adjunct to hand washing in reducing microbial contamination and spread; and (2) urge the placement of alcohol-based hand sanitizer dispensers outside of public restrooms and in highly trafficked areas. (MSS Amended Res 20, A-09) (AMA Res 908, I-09 [H-440.857]) (Reaffirmed: MSS GC Rep A, I-14)

440.034MSS Medical Student Involvement in Disaster Medicine and Public Health Preparedness Planning and Response: AMA-MSS will ask the AMA to support skill-appropriate medical student involvement in pandemic disaster medicine and public health preparedness planning and response. (MSS Res 14, I-09) (AMA Res 311, A-10 Referred) (Reaffirmed: MSS GC Rep A, I-14)

440.035MSS Increasing Advocacy for and Public Awareness of the Lack of a Vaccine-Autism Link: AMA-MSS will ask the AMA to ask the Office of the Surgeon General for a definitive repudiation of the link between developmental disorders, such as autism, and either thimerosol-containing vaccines or the MMR vaccine. (MSS Res 24, I-09) (AMA Res 413, A-10 Adopted [H-440.853]) (Reaffirmed: MSS GC Rep A, I-14)

440.036MSS Support for Establishment of Minimum Requirements for Training of Personnel Administering Medical Radiation: AMA-MSS will ask the AMA to support efforts to establish minimum standards for personnel performing medical procedures using ionizing radiation to be appropriately educated and trained in order to avoid patient over-radiation.
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440.037MSS AMA-MSS Support for FDA Efforts to Reduce Computed Tomography Radiation in Children: AMA-MSS (1) supports the current US Food and Drug Administration policy including; promoting the safe use of medical imaging devices, supporting informed clinical decision making and increasing patient awareness; (2) supports working with all relevant parties to advocate for inclusion of an individual registry containing the patient’s historical (test and procedure-based) cumulative radiation dose, as well as research the fiscal impact such a registry would incur; (3) encourages the continued development and use of standardized electronic medical record systems that will help physicians track the number of imaging procedures a patient is receiving and that will help physicians discuss the potential dangers of high level of radiation exposure with patients; and (4) supports initiatives to increase awareness of ionizing radiation exposure from medical imaging and practices that lower radiation exposure from medical imaging. (MSS Res 41, I-11) (Reaffirmed: MSS GC Report A, I-16)


440.039MSS Support for Service Animals, Animals in Healthcare, and Medical Benefits of Pet Ownership: AMA-MSS will ask the AMA to (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit. (MSS Res 45, I-11) (Reaffirmed: MSS GC Report A, I-16) (Modified: MSS Res 12, I-16) (AMA Res 508, A-17 Referred)

440.040MSS Increased Advocacy for Hepatitis C Virus Education, Prevention, Screening, and Treatment: AMA-MSS will ask the AMA to (1) encourage the adoption of age-based screening practices for hepatitis C, in alignment with recent Centers for Disease Control recommendations; and (2) to encourage increased resources for Centers for Disease Control and state Departments of Public Health for the development and coordination of Hepatitis C Virus infection educational and prevention efforts. (Sub MSS Res 45, A-12)

440.041MSS Accounting for Socioeconomic Status in Clinical and Public Health Research: AMA-MSS will ask the AMA to study the literature regarding the inclusion of socioeconomic status data in clinical and public health research so as to recommend future inclusion of appropriate minimum standards. (MSS Res 15, I-12) (Amended AMA Res 502, A-13 Adopted) (Reaffirmed: MSS GC Report A, I-17)

440.042MSS Permitting Sunscreen in Schools: AMA-MSS will ask the AMA to (1) support the exemption of sunscreen from over-the-counter medication possession bans in schools and to encourage all schools to allow students to bring and possess sunscreen at school without restriction; and (2) encourage schools to allow teachers to provide students with sunscreen, without requiring the teacher to assist in application. (MSS Res 18, I-12) (Amended AMA Res 403, A-13 Adopted [H-460.980]) (Reaffirmed: MSS GC Report A, I-17)

440.043MSS Promoting Celiac Disease Screening Usage and Standards: AMA-MSS (1) recognizes undiagnosed celiac disease as a public health problem; and (2) supports the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders. (MSS Res 14, A-13)
440.044MSS Sunscreen and Sun Protection Counseling by Physicians: AMA-MSS will ask the AMA to encourage physicians to counsel their patients on sub-protective behavior. (MSS Res 26, I-13)

440.045MSS Development of a Standardized Post-Conducted Electrical Devise Exposure Medical Protocol and Educational Campaign: AMA-MSS will ask the AMA to (1) encourage appropriate organizations and medical specialty societies to develop a standardized, post-exposure medical protocol for the use of conducted electrical devices (CEDs) using recent advances in the understanding of the risks associated with CEDs; and (2) support the incorporation of a standardized post-conducted electric device (CED)-exposure medical protocol into law enforcement procedures and training. (MSS Res 28, I-13)

440.046MSS Prevention of Mosquito Transmitted Diseases: AMA-MSS will ask the AMA to encourage physicians to discuss and promote protective practices specific for mosquitoes, such as those developed by the Centers for Disease Control, with patients when clinically appropriate. (MSS Res 36, I-13)

440.047MSS Support for a Minimum Requirement for Vaccine Opt-Outs: AMA-MSS supports legislation that requires Vaccine Opt-Out forms to be cosigned by both a patient or guardian and healthcare professional acknowledging that the healthcare professional has discussed the risks and benefits of immunization including the risks to the patient and community resulting from declining vaccinations. (MSS Res 9, A-14)

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

440.049MSS Labeling and Recommended Protection for Sunglasses: AMA-MSS will ask the AMA to: (1) recognize based on current evidence that sunglasses that protect against 100% of both UVA and UVB radiation are currently the safest choice for consumers; and (2) recommend that manufacturers clearly label all sunglasses with the percentage of UVA and UVB radiation reflected so that consumers know the extent to which the glasses protect against both types of UV radiation. (MSS Res 17, I-14)

440.050MSS Measuring the Effect of Paid Sick Leave (PSL) on Health-Care Outcomes: AMA-MSS will ask the AMA to: (1) recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and (2) work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted legislation. (MSS Res 28, I-14) (AMA Res 202, A-15 Referred)

440.051MSS A Comprehensive Education Strategy to Improve Vaccination Rates: AMA-MSS (1) supports national, evidence-based education of parents by clinicians and reputable public health organizations about the risks and benefits of immunization to both children and the community at large to combat the public health threat that under-immunization poses; (2) supports the development of resources for physicians aimed at improving patient education regarding the safety of vaccines, their effectiveness at preventing communicable diseases, and the importance of maintaining herd immunity; and (3) will ask the AMA to partner with appropriate stakeholders to sponsor a national, evidence-based public service announcement campaign aimed at increasing the vaccination rate. (MSS Res 4, A-15) (Recommendations in CSAPH Rep 1 Adopted as Amended in Lieu of AMA Res 904, I-15)

440.052MSS Support for Municipal Ordinances that Promote Green Space in Residential Zoning Districts: AMA-MSS ask the AMA to support appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve

440.053MSS Support for Mandatory Vaccination: AMA-MSS (1) asks the AMA to reaffirm policy H-440.970; (2) encourages schools to report student vaccination rates and exemption rates to parents and guardians prior to annual student enrollment; and (3) supports the establishment of national vaccine requirements for minors. (MSS Res 21, A-15)

440.054MSS Increase Advocacy and Research into the Effects of Police Brutality on Public Health Outcomes: AMA-MSS will ask the AMA to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly members of ethnic and racial minority communities. (MSS Res 32, A-15) (AMA Res 910, I-15 Not Considered) (AMA Res 406, A-16 Adopted as Amended [H-515.955])

440.055MSS Oil and Gas Well-Stimulation Disclosure and Moratorium: AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction. (MSS Res 48, A-15)

440.056MSS Radon Testing in Rentals: AMA-MSS will ask that our AMA support transparency and disclosure in prior radon testing, the most recent results of such testing, prior mitigation or remediation efforts, and other relevant information to protect renters and tenants when entering into a lease. (MSS Res 25, I-15) (Amended Policy H-455.986 Adopted in Lieu of AMA Res 505, A-16)

440.057MSS Improving Detection, Awareness, and Prevention of Lead Contamination in Water: (1) Our AMA-MSS supports future research to improve water sampling techniques and protocols to better detect human exposure to lead at the point of consumption; (2) Our AMA-MSS supports improved open public access to testing data on health hazardous substance levels in public commodities, such as water; and (3) Our AMA-MSS supports legislation and efforts to reduce or eliminate lead from public and private water infrastructure. (MSS Res 23, A-16)

440.058MSS Importance of Oral Health in Medical Practice: AMA-MSS (1) recognizes the importance of managing oral health as a part of overall patient care; (2) supports efforts to educate physicians on oral condition screening and management, as well as the consequences of poor oral hygiene on mental and physical health; (3) supports closer collaboration of physicians with dental providers to provide comprehensive medical care; and (4) support efforts to increase access to oral health services. (MSS Res 22, I-16)

440.059MSS Improving Access to Direct Acting Antivirals for Hepatitis C-Infected Individuals: The AMA-MSS (1) supports hepatitis C virus (HCV) treatment programs aimed at reducing the public health burden of the HCV epidemic; (2) will ask that our AMA support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV, particularly those providers serving rural or otherwise underserved populations; and (3) will ask that our AMA amend current policy H-440.845 by addition to read as follows:

**Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845**

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support educational programs aimed at training primary care providers in the treatment and management of patients infected with HCV (4) (5) support adequate funding by,
and negotiation for affordable pricing for HCV antiviral treatments between, the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) (6) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

(MSS Res 28, I-16) (AMA Res 410, A-17 Adopted as Amended [H-440.845])

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

**Eradicating Homelessness H-160.903**

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

(MSS Res 38, I-16) (AMA Res 208, A-17 Referred)

**Expanding Expedited Partner Therapy to Treat Trichomoniasis:** AMA-MSS will ask that our AMA amend policy H-440.868 by addition and deletion as follows:

**Expedited Partner Therapy H-440.868**

Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, and/or chlamydia, and/or trichomoniasis infection.

(MSS Res 03, A-17)

**Addressing Foster Care Healthcare Needs:** AMA-MSS will ask that our AMA advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children. (MSS Res 17, A-17)

**Recognizing Poverty-Level Wages as a Social Determinant of Health:** AMA-MSS (1) declares poverty-level minimum wages a negative social determinant of health; and (2) supports efforts that address poverty level wages to alleviate their role as a negative social determinant of health. (MSS Res 37, A-17)

**Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data:** AMA-MSS will ask the AMA to (1) oppose policies that enable racial housing segregation and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (MSS Res 12, I-17)
Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic: AMA-MSS will ask the AMA to 1) acknowledge HPV Vaccines as beneficial to all genders as anti-cancer and anti-STI; and (2) support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs. (MSS Res 15-I-17)

Opposition to Measures That Criminalize Homelessness: AMA-MSS will ask the AMA to 1) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; and (2) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights. (MSS Res 20-I-17)

Food and Drug Administration Conflict of Interest: AMA-MSS will ask the AMA to (1) advocate for a reduction of conflict of interested wavers graded to Advisory Committee Candidates, and (2) advocate the Food and Drug Administration place a greater emphasis on candidates’ conflict of interest when selection members for advisory committees (MSS Res 18-I-17)

Support for Public Health Violence Prevention Programs: AMA-MSS will ask the AMA to support legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence. (MSS Res 78-I-17)

Increased Access to Identification Cards for the Homeless Population: AMA-MSS will ask the AMA to (1) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental services that support healthy lifestyle; (2) support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; and (3) promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge. (MSS Res 27, A-18)

Increasing Availability of Bleeding Control Supplies: AMA-MSS will ask the AMA to amend Policy H-130.935 by addition as follows:

**H-130.935: Support for Hemorrhage Control Training**

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

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

3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings. (MSS Res 27, I-18) (AMA Res 527, A-19, Adopted as amended [H-130.935])

Improving the Health and Safety of Consensual Sex Workers: AMA-MSS will ask the AMA to recognize the adverse health outcomes of criminalizing consensual sex work. (MSS Res 05, A-19)

Sunscreen Dispensers in Public Spaces as a Public Health Measure: AMA-MSS will ask the AMA to support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (MSS Res 28, A-19)
440.073MSS Increasing Access to Gang-Related Tattoo Removal in Prison and Community Settings: AMA-MSS will ask the AMA to support increased access to gang-related tattoo removal in prison and community settings. (MSS Res 31, A-19)

440.074MSS The Effects of Employment Discrimination on the Health of Formerly Incarcerated Individuals: AMA-MSS supports policies and practices that prevent employers from discriminating against formerly incarcerated individuals. (MSS Res 34, A-19)

440.075MSS Support for Research of Boxes for Babies Sleeping Environment: AMA-MSS will ask the AMA to support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States. (MSS Res 13, I-17)

440.076MSS Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: AMA-MSS will ask the AMA to 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. (MSS Res 46, A-18) (AMA Res 528, A-19, Adopted [H-60.990])

440.077MSS Compassionate Release for Incarcerated Patients: AMA-MSS will ask the AMA to (1) support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; (2) collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and (3) promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions. (MSS Res 04, I-18) (AMA Res 430, A-19, Referred)

440.078MSS Support for Universal Basic Income Pilot Studies: AMA-MSS will ask the AMA to support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants. (MSS Res 19, I-18) (AMA Res 236, A-19, Referred)

440.079MSS Medical Respite Care for Homeless Adults: AMA-MSS will ask the AMA to study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (MSS Res 42, I-17) (AMA Res 416, A-18, Appended [H-160.903])

440.080MSS Ending Money Bail to Decrease Burden on Lower Income Communities: AMA-MSS will ask the AMA to support legislation that ends pre-trial financial release options for individuals charged with non-violent crimes. (MSS Res 55, I-17) (AMA Res 408, A-18, Adopted [H-80.993])

440.081MSS Adverse Impacts of Delaying the Implementation of Public Health Regulations: AMA-MSS will ask the AMA to (1) examine the feasibility of filing an amicus brief highlighting the detrimental health effects of municipal solid waste landfill pollution in Court Case #18-cv-03237 (State of California et. Al v EPA et. Al); 2) amend H-135.950 Support the Health-Based Provisions of the Clean Air Act to Read as follows:

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; (3) opposes further legislation, rules, and regulations that weakens the existing provisions of the Clean Air Act; and (4) support updates to the
Risk Management Program such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public;

3) recognize the significant health risks associated with pesticide exposure; 4) urge the EPA and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children; and 5) analyze ongoing regulation delays that impact public health, as deemed appropriate. (MSS CGPH Rep A, I-18) (AMA Res 529, Adopted as Amended [D-440.925])

445.000MSS Public Relations

445.001MSS Public Image of Physicians: (1) AMA-MSS: (a) will help develop community service and public education programs that serve to inform the public of health care issues and improve the public image of the AMA and the medical profession; and (b) will investigate possible advantages of involving medical students in AMA efforts to improve the public image of physicians and to assure the public that the primary role of physicians today continues to be that of advocates for their patient's health. (MSS Sub Res 25, I-85) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Modified: MSS GC Rep A, I-16)


450.000MSS Quality of Care


450.002MSS Eliminating Medical Tubing Misconnections: AMA-MSS supports the manufacture and use of medical tubing with designed incompatibility such that it is physically impossible to connect tubing intended for different health functions. (MSS Res 41, I-10) (Reaffirmed: MSS GC Rep D, I-15)

460.000MSS Research

460.001MSS Pure and Applied Research: AMA-MSS supports the following principles: (1) A commitment to stabilization of support for biomedical research and research training should be made by the government. (2) Private funding of academic research should be encouraged through a system of financial incentives. (3) The public's interest in a product of biotechnology, which it has substantially funded, should be protected even if commercial interests have funded the latter stages of the product's development. (4) In any system of regulation or incentive regarding private sponsorship of academic research, provisions should be made to actively encourage the role of training researchers as well as the role of conducting research. (5) Individuals and institutions must police themselves in order to combat overly restrictive regulation. (6) Greater decentralization of the decision-making authority from federal agencies to grantee institutions should occur, especially in the day-to-day management of grants and contracts. (7) Medical
school admissions committees should develop criteria that do not penalize applicants who express interest in pursuing careers in biomedical research. (8) Federal support for training physician-scientists should be strengthened. (9) Medical schools should make available adequate elective laboratory research experience in the basic science years for those students interested. (MSS Rep C, I-82, Attachment 6) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

460.002MSS Biomedical Research & Research Training: AMA-MSS will apply its existing policy of support for biomedical research and research training by (1) continuing its support of the established peer review system whereby research funds are granted and (2) opposing any attempts to increase direct congressional control over the specific allocation. (MSS Sub Res 10, A-84) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

460.004MSS Human Genome Project: AMA-MSS will ask the AMA to: (1) endorse the scientific and medical objectives of the Human Genome Project; and (2) ask appropriate medical and scientific organizations to: (a) encourage worldwide support including monetary support, of advances in human genome research; (b) promote the free and open exchange of sequence information among nations; and (c) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind. (AMA Res 279, A-90 Adopted [H-460.962]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

460.005MSS Scientific Implications of Somatic Cell Nuclear Transfer Technology: AMA-MSS will ask the AMA to: (1) recommend a cessation of human somatic cell nuclear transfer research by both public and private sectors that involves the production of human beings; (2) work closely with the federal research funding agencies (NIH, NSF, NCI) and the Food and Drug Administration to determine if longitudinal animal studies indicate that nuclear transfer technology is safe and reproducible; and (3) encourage the applications of nuclear transfer technology for uses other than human reproduction by supporting basic science research programs that pursue medically therapeutic procedures such as organ or tissue transplantation. (MSS Sub Res 11, A-98) (AMA Res 11, A-98 Adopted [H-460.915]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

460.007MSS AMA Support for Manned Space Exploration of the Moon, and Mars that will Promote Medical Research and Enhance Patient Care: AMA-MSS will ask the AMA to publicly support a commitment for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care. (MSS Res 7, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Modified: GC Rep A, I-16)

460.008MSS Support for Increased Regulation in Tissue Procurement: AMA-MSS will ask the AMA to (1) support efforts by the FDA, the American Association of Tissue Banks, CDC, and other appropriate establishments to institute a uniform system of tissue tracking and a national database of tissue registry for tissues intended for nonclinical scientific and educational purposes; and (2) reaffirm AMA Policy H-370.988 – Regulation of Tissue Banking. (MSS GC Report F, A-07) (AMA Policy Reaffirmed in Lieu of AMA Res 702, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

460.009MSS Support for Increase in Federal Funding for the National Institutes of Health: AMA-MSS supports sufficient increases in National Institutes of Health funding to cover the rising cost of research. (MSS Sub Res 9, A-08) (Existing Policy Reaffirmed in Lieu of AMA Res 912, I-08) (Modified: GC Rep B, I-13)
460.011MSS  **Comparative Effectiveness Research:** It is policy of the AMA-MSS to support the creation of an independent organization that: (1) Conducts and supports research into the comparative effectiveness and cost effectiveness of new and existing medical interventions to increase information available for clinical decision-making; (2) publicly disseminates findings to medical professionals and patients; (3) involves representatives of physicians and patients in its governance; (4) ensures that all studies maintain the highest standards of scientific credibility and investigator integrity, including submission of studies through a peer-review process and rules regarding conflicts of interest; (5) receives funding from a dedicated funding source or sources not subject to Congressional appropriations; (6) recognizes that patients are unique individuals and while attempting to provide evidence for specific subgroups and circumstances, acknowledges that population-level research is not applicable to every clinical case; (7) does not make recommendations for public or private insurance coverage decisions or payment policies; and (8) does not issue physician practice guidelines. (MSS Amended Res 18, I-08) (Reaffirmed: MSS GC Report B, I-13)

460.012MSS  **Encouraging Research into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients:** AMA-MSS will ask the AMA to encourage research into the impact of long-term administration of hormone replacement therapy in transgender patients. (MSS Res 18, A-10) (AMA Res 512, A-11 Adopted [H-460.907]) (Reaffirmed, MSS GC Rep D, I-15)

460.013MSS  **Medical Ghostwriting:** AMA-MSS will ask the AMA to educate, at appropriate intervals, physicians and physicians-in-training about the currently-defined differences between being an “author” and being a “contributor” as well as the varied potential for industry bias between these terms and the importance of self-identifying between these terms when submitting manuscripts for publication in accordance with the following text: (1) Authorship credit should be based on (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (b) drafting the article or revising it critically for important intellectual content; and (c) final approval of the version to be published. Authors should meet conditions all three conditions. Those meeting fewer than all three criteria should be considered contributors. (2) When a large, multicenter group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship/contributorship defined above and should complete journal-specific author and conflict-of-interest disclosure forms. When submitting a manuscript authored by a group, the corresponding author should clearly indicate the preferred citation and identify all individual authors as well as the group name. Journals generally list other members of the group in the Acknowledgments. The National Library of Medicine indexes the group name and the names of individuals the group has identified as being directly responsible for the manuscript; it also lists the names of collaborators if they are listed in Acknowledgments. (3) Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship but rather, contributorship. (4) All persons designated as authors should qualify for authorship, and all those who qualify should be listed. (5) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. (MSS Res 48, I-10) (AMA Res 311, A-11 Adopted with Change in Title [H-460.972]) (Reaffirmed: MSS GC Rep D, I-15)

460.014MSS  **Creation of National Registry for Healthy Subjects in Phase I Clinical Trials:** AMA-MSS will ask the AMA to encourage the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in phase I trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and document previous trial participation. (MSS Sub Res 35, A-11) (AMA Res 913, I-11 Adopted [D-460.972]) (Reaffirmed: MSS GC Report A, I-16)
460.015MSS Understanding Medical School Support for Student Participation in Year-Out Research Programs: AMA-MSS will work with the AMA Academic Physicians Section, the AMA Council on Medical Education, and other appropriate groups to encourage medical schools to facilitate student participation in year-out research programs. (GC Rep D, A-11) (Modified and Reaffirmed: MSS GC Report A, I-16)

460.016MSS The Next Transformative Project: In Support of the BRAIN Initiative: AMA-MSS will ask the AMA to (1) support 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) encourage appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative; and (3) evaluate the role of our organization in ensuring the proper execution of the BRAIN initiative. (MSS Res 17, A-13) (Amended AMA Res 522, A-13 Adopted [H-460.904])

460.017MSS Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials: AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; (2) sign the petition titled “All Trials Registered; All Results Reported” at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (3) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and (4) encourage the expansion of clinical trial registrants to clinicaltrials.gov. (MSS Res 23, A-15) (First, third, and fourth Resolves of Res 907, I-15 Adopted as Amended, H-460.912 and D-460.970 Reaffirmed)

460.018MSS Removing Restrictions on Federal Public Health Crisis Research: AMA-MSS will ask (1) that our AMA recognize the importance of timely research and open discourse in combatting public health crises; and (2) That our AMA oppose efforts to restrict funding or suppress the findings of biomedical and public health research for the purpose of influencing political discourse. (MSS Res 15, A-16).

460.019MSS Removing Restrictions on Federal Funding for Firearm Research: AMA-MSS will ask that our AMA provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions. (MSS Res 16, A-16)

460.020MSS Reintroduction of Mitochondrial Donation in the United States: AMA-MSS will ask the AMA to support regulated research to determine the efficacy and safety of mitochondrial donation as a means of preventing the transmission of mitochondrial diseases to at-risk males. (MSS Res 70-I-17)

460.021MSS Researching Drug Facilitated Sexual Assault Testing: AMA-MSS will ask the AMA to study the feasibility and implications of offering drug testing at point of care for date rape drugs, including but not limited to rohypnol, ketamine, and gamma-hydroxybutyrate, in cases of suspected non-consensual, drug-facilitated sexual assault. (MSS Res 69-I-17)

460.022MSS Support for Preregistration in Biomedical Research: AMA-MSS will ask the AMA to support pre-registration of research studies to mitigate publication bias and improve the reproducibility of biomedical research. (MSS Res 07, A-18)

460.100MSS Research: Animals
Use of Animals in Research and Education: (1) AMA-MSS encourages medical school faculty who use non-human animals in the training of students to instruct students about the appropriate use of animals as experimental subjects and encourages students and faculty to play an active role at their schools in developing institutional policies governing use of animals in laboratories and other classes at their schools; and (2) AMA-MSS will make a substantial effort to educate medical students about the necessity of well-designed and humane use of animals in research and education. (AMA Amended Res 93, I-83 Adopted [H-460.989]) (MSS Sub Res 4, A-88) (MSS Rep F, A-88) (Consolidated MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Rural Health

Rural Health Opportunities for Medical Students: AMA-MSS will ask the AMA to encourage medical schools to develop Divisions of Rural Health within their Departments of Family Practice and encourage rural physicians to help increase rural health opportunities for medical students by participating as members of the medical school academic environment. (AMA Amended Res 308, I-94 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Medical Drone Usual in Rural America: AMA-MSS promotes research on the use of medical drones in rural areas to deliver poorly stocked medical supplies, medical interventions and equipment. (MSS Res 02, I-18)

Sports and Physical Fitness


Weight Loss in Interscholastic Wrestlers: AMA-MSS will ask the AMA to actively endorse efforts by state level high school athletic associations to establish programs that include enforceable guidelines concerning weight and body fat changes on a pre-competition basis for those sports in which weight management is a concern. (AMA Res 401, I-95 Adopted [H-470.994]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Pre-Participation Screening in Student Athletes: AMA-MSS will ask the AMA to: (1) support the inclusion of the American Heart Association screening guidelines in the standardized pre-participation athletic examination for student athletes; and (2) recommend the use of further diagnostic modalities for those student athletes identified to be at risk by the American Heart Association screening guidelines, history, or physical examination. (MSS Amended Res 8, A-98) (AMA Res 409, I-98 Referred) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Modified: GC Rep B, I-13)

AMA Endorsement of National Bike to Work Day: AMA-MSS will ask the AMA to (1) support “National Bike to Work Day;” and (2) encourage active transportation whenever possible. (MSS Res 37, I-10) (AMA Res 604, A-11 Adopted [H-470.991]) (Reaffirmed: MSS GC Rep D, I-15)
Combating Childhood Obesity with Physical Education Requirements: AMA-MSS will ask the AMA to advocate that schools require a health care professional’s recommendation for students to opt out of physical education programs, in order to stress the importance of physical wellness among children and to promote healthy lifestyle choices that extend into adulthood. (MSS Res 39, I-10) (AMA Res 412 Referred, A-11) (Reaffirmed: MSS GC Rep D, I-15)

Bicycle Sharing Programs: AMA-MSS (1) supports city governments in their investigation of the feasibility and economic sustainability of bicycle sharing programs; and (2) supports implementation of a bicycle sharing program in cities where the feasibility, economic viability, and potential health impacts are favorable. (MSS Res 30, A-11) (Reaffirmed: MSS GC Report A, I-16)

Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention: AMA-MSS will ask the AMA to (1) support collegiate and professional athletic organizations adopting evidence-based guidelines for the evaluation and management of concussions; and (2) encourage further research into the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (MSS Res 20, A-13) (AMA Res 905, I-13 Adopted [H-470.957])

Encouraging the Research and Development of Concussion Tracking Technology in the Sport of Football: AMA-MSS supports the research and development of helmet and/or concussion tracking technology in order to develop safer concussion management protocols to protect players from long-term consequences of traumatic brain injuries and concussions in the sport of football at all levels. (MSS Res 46, A-15)

Supporting a Minimum Age Limit for Tackle Football: AMA-MSS will support the establishment of a minimum age limit in tackle football participants. (MSS Res 21, A-19)

Medical Technology Assessment: AMA-MSS supports the following principles: (1) Medical technology assessment should include societal, economic, ethical, and legal consequences of medical technologies, as well as concerns of safety and efficacy. (2) The medical community should stress the use of randomized, controlled clinical trials when ethical prior to the wide spread dissemination of medical technologies and emphasize the importance of clinical trials to health professionals. (3) Medical technologies should not be accepted as standard medical practice before they have been adequately assessed with respect to their safety, efficacy, cost-effectiveness and societal consequences. (4) Organized medicine should continue its involvement with the Prospective Payment Assessment Commission and should actively lobby for funding which would allow this body to accomplish its mandate with regard to medical technology evaluation. (5) Organized medicine should support the creation of a private/public sector consortium, as defined by the Institute of Medicine of the National Academy of Sciences, which would act as a clearinghouse for the evaluation of medical technologies. (6) Organized medicine should seek active representation in such a private/public sector consortium, and should research possible sources of funding (e.g., government, third party payers, technology producers). (7) Organized medicine should work to assure a mechanism for awarding competitive grants to fund high quality clinical trials for the assessment of medical technology. (MSS Position Paper 1, I-83) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Ultrasound Imaging: AMA-MSS (a) affirms that ultrasound imaging is within the scope of practice of appropriately trained physician specialists; (b) acknowledges that broad and diverse
use and application of ultrasound imaging technologies exists in medical practice; (c) affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staff and should be specifically delineated on the Department’s Delineation of Privileges form; and (d) believes that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and ensure that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty society. (MSS Emergency Resolution 1, I-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Report A, I-16)

480.005MSS “Keepsake” Fetal Ultrasonography: AMA-MSS will ask the AMA lobby the federal government to enforce the current FDA position, which views "keepsake" fetal videos as an unapproved use of a medical device, on non-medical use of ultrasonic fetal imaging. (MSS Res 26, I-04) (AMA Res 501, A-05 Adopted [H-480.955]) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

480.007MSS Novel Technologies in Biometrics and Medical ID Bracelets Used to Enhance Security and Quality of Care: AMA-MSS will ask the AMA to (1) encourage the use of biometric technologies, such as, but not limited to fingerprint and palm scanners, in hospitals and clinics 1. for patient identification to reduce health insurance fraud and 2. for providers to streamline and secure user authentication processes and better protect patient privacy; and(2) to amend H-130.987 by insertion and deletion as follows:

H-130.987 Emergency Medical Identification Aids

The AMA (1) urges worldwide use of the Emergency Medical Identification Symbol (Symbol); (2) urges that persons with special health problems wear a readily evident durable metal or plastic alerting device and that all persons carry a universal medical information card identifying family, friends and personal physicians; (3) urges that the Symbol be imprinted on alerting devices, on medical identification cards, and on emergency medical care educational material; and(4) encourages physicians to work individually with their patients in selecting an appropriate signal device and identification card; and (5) encourages health insurance providers to offer enrollment in a virtual medical ID bracelet identification alert system as an optional health service, which can offer emergency responders immediate access to pertinent health information and family contact information.


480.010MSS Web-Based Tele-Health Initiatives and Possible Interference with the Traditional Physician-Patient Relationship: AMA-MSS (1) supports our AMA urging the US Department of Health and Human Services (DHHS) to review tele-health initiatives being implemented by major health insurance carriers (i.e., United Healthcare, Blue Cross Blue Shield) and others to assure that proper standards of care are maintained, that such initiatives and the physicians who work with them are adherent to professional practice standards and federal public health laws and regulations; and to take appropriate actions to eliminate such initiatives that do not meet acceptable standards and regulations; and (2) supports our AMA seeking regulatory guidance from the DHHS regarding the essential requirements of web-based tele-health technology and health care initiatives and the requirements of physicians and healthcare providers who engage in the delivery of such services. (Sub Res 13, A-12) (Reaffirmed: MSS GC Report A, I-17)
480.011MSS Use of Integrated Pre-hospital Electronic Patient Care Reports for Pre-hospital Healthcare Providers: AMA-MSS will ask the AMA to support legislation incentivizing the comprehensive use of integrated electronic patient care reports by EMTs and paramedics for better cross communication, and to standardize the flow of information from pre-hospital to hospital. (MSS Res 14, A-12) (Reaffirmed: MSS GC Report A, I-17)

480.012MSS Preserving the Role of Physicians and Patients in the Evolution of Health Information Technology: AMA-MSS supports increasing the number of funded positions at all levels of graduate, medical, and allied health professional training in medical informatics to a level commensurate with current Health Information Technology (HIT) spending through mechanisms including, but not limited to, student research positions funded by National Institutes of Health (NIH) T and F programs. (MSS Res 14, I-12) (Reaffirmed: MSS GC Report A, I-17)

480.013MSS The Role of Medical Students in the Development of Health Information Technology: AMA-MSS will work with our AMA and other relevant organizations to (a) facilitate active and timely medical student input on Health Information Technology research and development; and (b) continually determine how best our AMA-MSS can assist in the improvement of Health Information Technology. (MSS Res 31, I-13)

480.014MSS Support of Interstate Medical Licensure Compacts: AMA-MSS supports the development and adoption by states of interstate medical licensure compacts or uniform acts to enhance medical license portability. (MSS Sub Res 15, I-14)

480.015MSS Implementing Medication Reminder Systems: AMA-MSS will ask the AMA to support research into the efficacy of electronic reminder systems. (AMA Sub Res 12, A-15) (Amended Policy H-373.933 Adopted in Lieu of AMA Res 906)

480.016MSS Implementation of Cost Effective Technologies as a Solution to Wandering Patients with Alzheimer’s Disease and Other Related Disorders: AMA-MSS will ask that our AMA support the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer’s disease and other related dementias with the help of appropriate allied specialty organizations. (MSS Res 16, I-15) (AMA Res 503, A-16 Adopted)

480.017MSS Secure Text Messaging Between Healthcare Providers: AMA-MSS supports usage of mobile devices messaging within clinical settings that is in compliance with the HIPAA Security Rule and minimally burdensome to healthcare providers. (MSS Res 18, I-16)

480.018MSS Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research: AMA-MSS will ask that our AMA study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (MSS Res 15, I-16) (AMA Res 509, A-17 Existing Policy H-480.943 Reaffirmed in lieu of Res 509)

480.019MSS Best Practices for Mobile Medical Applications: That our AMA develop and publicly disseminate a list of best practices guiding the development of mobile medical applications. (MSS Res 10, I-14)

480.020MSS Healthcare Applications for Blockchain Technology: AMA-MSS will study potential risks and benefits that blockchain technology may have on the healthcare industry, including but not limited to health care costs, security, interoperability, and claims adjudication. (MSS Res 25, I-17)
480.021MSS  **Machine Intelligence and Data Science Literacy:** (1) AMA-MSS supports the development of core physician data science competency guidelines; and (2) AMA-MSS encourages medical schools to explore the implementation of more robust data science education. (MSS Res 36, A-18)

480.022MSS  **Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications:** AMA-MSS will ask our AMA to amend policy D-480.972 to read as follows:

Guidelines for Mobile Medical Applications and Devices D-480.972

1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement.
2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based.
4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows.
6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training.
7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments.
8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations.

(MSS Res 10, A-19)

480.023MSS  **Net Neutrality and Public Health:** AMA-MSS will ask the AMA to 1) advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; 2) collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and 3) oppose internet data transmission practices that reduce market competition in the health ecosystem. (MSS CHIT/CEQM Rep A, I-18)

480.024MSS  **Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized:** AMA-MSS will ask the AMA to (1) work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare; and (2) continue to monitor the evolution of blockchain technologies in healthcare and engage in discussions with appropriate stakeholders regarding blockchain development. (MSS CHIT/CEQM Rep A, I-18) (AMA Res 237, A-19, Adopted as Amended [D-478.962])
485.000MSS  
**Television**

485.001MSS  
**Television Broadcast of Sexual Encounters and Public Health Awareness:** AMA-MSS will ask the AMA to urge television broadcasters, producers, and sponsors to encourage education about safe sexual practices, including but not limited to condom use and abstinence, in television programming of sexual encounters, and to accurately represent the consequences of unsafe sex. (AMA Amended Res 421, I-91 Adopted [H-485.994]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

485.002MSS  
**Support for Increased Educational Children's Television Programming:** AMA-MSS will ask the AMA to encourage independent television stations and network affiliates throughout the U.S. to broadcast at least one hour per day, during regular viewing hours, of educational programming for children. (AMA Res 404, A-96 Adopted [H-485.992]) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

485.003MSS  
**Machine Intelligence in Healthcare:** AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision-making, including diagnosis, patient care, and health systems management; (3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) supports increased utilization of the term "machine intelligence" rather than the term "artificial intelligence" when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making. (MSS Res 37-I-17) (Reaffirmed: MSS Res 22, A-19)

490.000MSS  
**Tobacco**

490.004MSS  

490.005MSS  
**"Smoke Free" Educational:** AMA-MSS will ask the AMA to: (1) encourage departments of education, through state and local medical societies, to expand health education programs targeted at 12 to 18 years old; (2) urge state societies to promote the use of the educational film "Death in the West", the educational program "Counseling Leadership About Smoking Pressure" (CLASP), and/or other programs that have demonstrated reductions in tobacco use by young people; and (3) work with the American Lung Association, American Heart Association, and the American Cancer Society to develop a list of physicians recommended as speakers for local television and radio stations to discuss the ill effects of tobacco usage and to advocate a smoke-free society by the year 2000. (AMA Sub Res 110, I-85 Adopted) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

490.007MSS  
**Medical School Tobacco Stock Holdings:** AMA-MSS will ask the AMA to support the divestiture of tobacco stocks held by medical schools and universities. (AMA Res 45, I-86 Referred) (CME Rep D, A-87 Adopted) (Consolidated: CLRPD Rep 2, I-94) (Reaffirmed:
Regulation of Tobacco Products by the Food and Drug Administration: AMA-MSS will ask the AMA to support the regulation of tobacco products by the Food and Drug Administration. (AMA Res 243, A-89 Adopted [H-495.988]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16)

Tobacco Cessation Counseling: AMA-MSS will ask the AMA to: (1) urge third party payors and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; and (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction. (AMA Amended Res 411, I-92 Adopted [H-490.916]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


State Tobacco Tax Increases and Responsible Use of Resulting Funds: AMA-MSS will ask the AMA to support increases in the taxation of tobacco products with revenue from any such tax increases appropriated exclusively for the following uses: (1) educational, counter advertising and cessation programs designed to decrease the prevalence or the adverse effects of tobacco use, and (b) health related costs associated with tobacco use (MSS Res 8, A-03) (AMA Res 803, I-03 Referred to BOT) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Use of State Tobacco Tax Revenue and Tobacco Settlement Fund Tracking and Publishing: AMA-MSS will ask the AMA to work with other interested organizations to seek and publish state by state accounting information regarding the specific uses of all state tobacco taxes and tobacco settlement funds. (MSS Res 9, A-03) (Reaffirmed Existing Policy in Lieu of AMA Res 804, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Fighting Securitization of Tobacco Settlement Funds: AMA-MSS strongly opposes the securitization of tobacco settlement funds and supports the AMA in encouraging the issue of strong public statements condemning the growing movement to “securitize” tobacco settlement funds as a one-time fix for budget problems. (MSS Res 11, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Defining the Physical Boundaries and General Scope of Smoke-Free Policies on Medical Campuses and Other Institutions of Higher Education: AMA-MSS supports (1) the implementation of smoke-free policies on all medical campuses and institutions of higher education nationwide, wherein the geographic extent of the campus is defined as all buildings, facilities, grounds, and properties under the direct purview of the academic institution (in short, all properties owned by the institution, including all transportation vehicles), providing enforcement of such a policy does not interfere or conflict with state or federal law; (2) the enforcement of smoke-free policies at all institutions of higher education with the use of clearly displayed signs and placards, as well as the inclusion of information regarding the aforementioned policies in the institution’s policy statements and bylaws; and (3) a set of comprehensive guidelines on which other academic institutions should base their own smoke-free policies. (MSS Res 23, A-10) (Reaffirmed, MSS GC Rep D, I-15)
490.0221MSS Providing Full Coverage for Smoking Cessation Treatments: AMA-MSS (1) supports working with state and local medical societies to formally request that state lawmakers allocate at least the Centers for Disease Control and Prevention-recommended minimum amount of the state’s Tobacco Settlement Fund award annually to tobacco cessation programs; and (2) recommends that third-party payers and government agencies involved in medical care offer full coverage for smoking cessation products to smokers seeking counseling for quitting. (MSS Res 38, I-11) (Reaffirmed: MSS GC Report A, I-16)

490.0222MSS Federal Excise Tax for Tobacco Products: AMA-MSS will advocate for legislation establishing a federal excise tax on cigarettes such that the total cost of taxation of cigarettes will be indexed to the best available estimate of smoking-related health costs of a pack of cigarettes. (MSS Res 31, A-10) (Reaffirmed, MSS GC Rep D, I-15)

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

490.025MSS Improved Regulations on Electronic Nicotine Delivery Systems (ENDS) and Electronic Cigarettes: AMA-MSS will (1) acknowledge the known harms of electronic nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices, and encourage physicians to recommend alternative therapies for smoking cessation; (2) work with federal agencies to discourage the promotion of electronic nicotine delivery systems both among adolescents and as smoking cessation devices; and (3) support increasing the age of purchase for all tobacco products from age 18 to 21. (MSS Res 28, A-18)

500.000MSS Tobacco: Marketing and Promotion

500.003MSS Tobacco Advertising Tax Deduction: AMA-MSS will ask the AMA to: (1) continue to support legislation to reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products; and (2) advocate that the added tax revenues obtained as a result of reducing or eliminating the tobacco advertising/promotion tax deduction be utilized by the federal government for expansion of health care services, health promotion, and education. (AMA Amended Sub Res 204, A-93 Adopted [H-500.979]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


500.005MSS International Ban on Tobacco Advertising: AMA-MSS supports the AMA in a national and international ban within constitutional protections on tobacco advertising and in encouraging the U.S. government to include a ban on tobacco advertising in the international treaty on tobacco controls. (MSS Res 12, A-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Report A, I-16)

500.006MSS Restricting the Sale of E-Cigarettes to Minors: AMA-MSS supports (1) increased clinical research on the effects of electronic cigarettes; and (2) education on the effects of e-cigarettes
to parents and their children in various settings ranging from schools to clinics. (MSS Res 1, A-14)

**505.000MSS  Tobacco: Prohibitions on Sale and Use**


**505.002MSS  Banning or Restricting Smoking in Public Places:** AMA-MSS will ask the AMA to: (1) encourage and support efforts, legislative and otherwise, to ban or restrict smoking in all public places; (2) define "public places"; (3) ask that smoking be banned in public places where division into "smoking" and "no smoking" areas was not feasible; (4) ask that "no smoking" sections be large enough to accommodate the non-smokers who wish to utilize them; and (5) encourage that legislation in this area satisfy the four elements identified by the American Lung Association as important in assuring effective anti-smoking legislation. (AMA Res 86, I-79 Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**505.005MSS  Elimination of Smoking in Public Places and Businesses:** AMA-MSS will ask the AMA to pursue legislation for states and counties to eliminate smoking in public places and businesses. (AMA Res 171, I-89 Adopted [H-490.913]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Rep A, I-16)

**505.006MSS  Smoking in Prisons:** AMA-MSS will ask the AMA to: (1) support legislation banning smoking in prisons and jails; and (2) reaffirm its commitment to smoking cessation programs in correctional facilities. (AMA Res 229, A-93 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**505.009MSS  Community Enforcement of Restrictions on Adolescent Tobacco Use:** (1) AMA-MSS will support the development and distribution of educational materials designed to educate members and the public regarding FDA regulations on reporting sales of tobacco to minors. (2) AMA-MSS believes that these materials (which may include but are not limited to the current toll-free number) should be available at all sites of tobacco sales. (MSS Amended Sub Res 36, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

**505.010MSS  Smoke-free Workplaces:** AMA-MSS will ask the AMA to: (a) draft model legislation to eliminate smoking in public places and businesses; and (b) encourage individual medical students, residents, and physicians – as well as medical schools, hospitals, clinics, and physician practices – to endorse, support, and lobby for legislation to eliminate smoking in public places and businesses as a “workers right” issue. (MSS Res 1, I-02) (AMA Sub Res 923, I-02 Adopted [H-505.966]) (Amended: MSS Rep C, I-07) (Modified and Reaffirmed: MSS Rep C, I-12) (Modified and Reaffirmed: MSS GC Rep A, I-17)

**505.011MSS  Opposing the Sale of Tobacco in Retail and Grocery Stores:** AMA-MSS will ask the AMA to support that the sale of tobacco products be restricted to tobacco specialty stores. (MSS Res 37, I-03) (AMA Res 413, A-04 Adopted [H-495.986]) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)
505.012MSS National Legislation Banning Smoking in Food Establishments: AMA-MSS will and will ask the AMA to actively pursue national legislation banning smoking in all cafeterias, restaurants, cafes, coffee shops, food courts or concessions, supermarkets or retail food outlets, bars, taverns, or in a place where food or drink is sold to the public and consumed on the premise. (MSS Amended Res 17, A-05) (AMA Amended Res 903, I-05 Adopted [D-490.979]) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

505.013MSS Amending H-490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing to Include E-Cigarettes: AMA-MSS will ask the AMA to amend policies H-490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes, to read as follows:

Smoke-free and Vape-free Environments and Workplaces H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke and vape exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry, and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy lifestyle for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to following the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person’s health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a non-smoking or a non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its
membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

Tobacco Smoke and Vaping Exposure of Children in Multi-Unit Housing to Include E-Cigarettes H-490.907

Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing. (MSS Res 03, A-19)

515.000MSS Violence and Abuse

515.001MSS Identifying Victims of Adult Domestic Violence: AMA-MSS will ask the AMA to: (1) work with social services and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of adult domestic violence and to better serve all of the victim's needs including medical, legal and social aspects; and (2) ask the appropriate organizations to support the inclusion of curricula that address adult domestic violence (AMA Res 419, I-91 Adopted [D-515.985]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

515.002MSS Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence: AMA-MSS will ask the AMA to: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats and stalking; and (2) support greater national and local protection for physicians and support personnel providing legal medical services. (AMA Sub Res 215, I-93 Adopted [H-460.945]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

515.003MSS Screening Groups at High Risk for Homicide and Violent Injuries: AMA-MSS will ask the AMA to support the development and issuance of educational advisories, materials, and resources for physicians to assist them in identifying, counseling, and referring individuals at high risk of homicide or violent injury. (AMA Res 403, I-94 Referred) (BOT Amended Rep 9, I-95 Adopted in Lieu of Res 403, I-94) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

515.005MSS Protection of the Privacy of Sexual Assault Victims: AMA-MSS will ask the AMA to condemn the publication or broadcast of sexual assault victims’ names, addresses, or likenesses without the explicit permission of the victim. (MSS Sub Res 21, I-97) (AMA Res 406, A-98 Adopted [H-515.967]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

515.007MSS Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse: AMA-MSS will ask the AMA to work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected. (MSS Sub Res 1, I-08) (AMA Res 415, A-09 Adopted [D-515.982]) (Reaffirmed: MSS GC Report A, I-14)

515.008MSS The Identification and Protection of Human Trafficking Victims: AMA-MSS (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients; (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services; (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and (4) encourages physicians to act as first responders in addressing human trafficking. (MSS Res 19, A-12) (Reaffirmed: MSS GC Report A, I-17)

515.009MSS Addressing Sexual Assault on College Campuses: AMA-MSS will ask our AMA support universities’ implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting. (MSS Res 7, I-15) (AMA Res 402, A-16 Adopted [H-515.956])

515.010MSS Sexual Assault Survivors’ Rights: AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors’ rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. (MSS Res 21, A-17)

515.011MSS Increased Use of Body-Worn Cameras by Law Enforcement Officers: AMA-MSS will ask that our AMA advocate for legislative, administrative, or regulatory measures to expand funding for (i) the purchase of body-worn cameras and (ii) training and technical assistance required to implement body-worn camera programs. (MSS Res 43, A-17)
Collecting and Releasing Data on Law Enforcement Use of Force: AMA-MSS supports the collection of data by the CDC and state departments of health on serious law-enforcement-related injuries and deaths and supports making law-enforcement-related deaths a notifiable condition. (MSS Res 45, A-17)

Trauma-Informed Care Resources: AMA-MSS will ask the AMA to (1) recognize trauma-informed care, as defined by stakeholders as a practice that realizes the widespread impact of trauma on all patients, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma into policies, procedures, and practices, seeks to avoid re-traumatization, and understands potential paths for recovery; and (2) support trauma-informed care by directing physicians to evidence based resources. (MSS Res 21, I-18) (AMA Res 526, A-19 [H-515.952])


Nuclear, Biological, And Chemical Terrorism: AMA-MSS will ask the AMA to: (1) work with the appropriate agencies (e.g. FEMA, DOD) to support ongoing efforts for medical preparedness in the case of a nuclear, biological or chemical (NBC) emergency, including but not limited to terrorist action; and (2) consider what training is necessary regarding nuclear, biological, and chemical agent education for civilian medical schools and residency training programs. (MSS Sub Res 28, I-98) (CSA Rep 4, A-99 Adopted in Lieu of Res 432, A-99 [H-130.949]) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

Ensuring High Quality Care for All Veterans and Their Families: Our AMA-MSS supports all avenues available to guarantee access to high quality health care for all eligible veterans and their families. (MSS Res 19, I-15)

Inclusion of Women in Clinical Trials: AMA-MSS encourages the inclusion of women, including pregnant women, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women. (AMA Res 183, I-90 Adopted [H-525.991]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report A, I-16) (Modified : MSS Res 31, I-16)

Surgical Modification of Female Genitalia: AMA-MSS will ask the AMA to: (1) encourage the appropriate obstetric/gynecologic and urologic societies in the United States to develop educational programs addressing medically unnecessary surgical modification of female genitalia, the many complications, and possible corrective surgical procedures; and (2) oppose

525.004MSS Discrimination of Women Physicians in Hospital Locker Facilities: AMA-MSS will ask the AMA to, request that the appropriate organizations require: (1) that male and female physicians have equitable locker facilities including equal equipment, similar luxuries, and equal access to uniforms; and (2) that if physical changes must be made to the hospital's locker facilities to comply with these requirements, that they must be budgeted and implemented within a period of five years of the adoption of these requirements. (AMA Res 810, A-93 Adopted [H-525.981]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report A, I-16)

525.005MSS Cancer Screening and Sexually Transmitted Infection (STI) Risk in Women Who Have Sex Exclusively with Women: AMA-MSS will ask the AMA to (1) educate physicians regarding the need for women who have sex exclusively with women for regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (2) support its partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk. (MSS Sub Res 3, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

Supporting the Inclusion of Pregnant Women in Research: AMA-MSS (1) supports the update of federal regulations on human subject research with a proactive and inclusive approach to pregnant women in clinical research; and (2) supports the prioritization and advancement of research on medications’ effect on pregnancy and breastfeeding. (MSS Res 31, I-16)

525.007MSS Decreasing Sex and Gender Disparities in Health Outcomes: AMA-MSS will ask the AMA to (1) promote the use of health care guidelines, protocols, and decision support tools that identify existing sex and gender differences and disparities in health care; and (2) encourage the use of guidelines, and treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes. (MSS Res 62-I-17)

Improved Accessibility of Feminine Hygiene Products for Incarcerated and Socioeconomically Disadvantaged Woman: AMA-MSS will ask the Internal Revenue Service to classify, and encourage the Internal Revenue Service to classify, feminine hygiene products as medical necessities; (2) support Flexible Spending Account, Health Savings Account, and Health Reimbursement Arrangement reimbursement of feminine hygiene products; and (3) support consistent and ready access of feminine hygiene products across all publicly funded institutions, including but not limited to housing units utilized by previously incarcerated and socioeconomically disadvantaged women. (MSS Res 50-I-17)

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products: AMA-MSS (1) supports improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; and (2) supports health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. (MSS Res 27-I-17)

Support for VA Health Services for Women Veterans: AMA-MSS recognizes the specific healthcare needs of the growing population of women veterans. (MSS Res 35-I-17)

525.010MSS Bridging the Gender Pay Gap: AMA-MSS (1) supports equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the
practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps. (MSS Res 30 I-18)

525.012MSS  Transparency Improving Informed Consent for Reproductive Health Services: AMA-MSS will ask the AMA to (1) work with relevant stakeholders to establish a list of Essential Reproductive Health Services, and (2) advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area. (MSS Res 23, A-19)

525.013MSS  Practice-Based Approach to Resolving Maternal Mortality and Morbidity in Racial Minorities: AMA-MSS supports development and implementation of evidence-based practices to prevent disease conditions that contribute to maternal morbidity and maternal mortality in racial and ethnic minorities. (MSS Res 42, I-18)

530.000MSS  AMA: Administration and Organization

530.003MSS  JAMA's Editorial Freedom: AMA-MSS (1) opposes the introduction of empowerment of a review board that would compromise JAMA's editorial freedom and independence; and (2) supports the concept that the editors of JAMA must have full authority for determining the editorial content of the journal. (MSS Sub Res 57, A-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

530.004MSS  Conference Registration Fees: AMA-MSS will encourage the AMA to offer, whenever feasible, a discounted registration fee not to exceed $100 to AMA student members for all AMA sponsored conference of interest to medical student members. (MSS Sub Res 27, I-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

530.006MSS  Donation of Medical Journals: AMA-MSS will ask the AMA to support and encourage the donation of medical journals, under 5 years old, to non-profit organizations for distribution to the international medical community. (AMA Amended Res 604, I-94 Adopted) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

530.012MSS  Product Endorsements: AMA-MSS supports policy whereby the AMA shall not endorse any products or services produced by other companies and marketed to consumers unless approved by the Board of Trustees, with no endorsements being made on an exclusive basis. (MSS Sub Res 5, I-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)


530.017MSS  Creation of a National Labor Organization for Physicians: AMA-MSS (1) supports the development and implementation by the AMA of a national bargaining unit under the National Labor Relations Act, consistent with our AMA Principles of Medical Ethics (Opinion 9.025), for employed physicians in professional practice, in order to retain the physician’s role as the patient advocate, (2) vigorously supports national and state antitrust relief that permits
collective bargaining between self-employed physicians and health plans/insurers/hospitals and others under the National Labor Relations Act, and (3) supports the development and implementation by the AMA of a national labor organization under the National Labor Relations Act consistent with our AMA Principles of Medical Ethics (Opinion 9.025) specifically for resident and fellow physicians. (MSS Amended Rep C, A-99) (Reaffirmed: MSS GC Report A, I-04) (Reaffirmed: MSS GC Report A, I-16)


530.023MSS Equal Opportunity in Professional Affiliations for Physicians: AMA-MSS will ask the AMA to: (1) urge its state medical associations and constituent societies to oppose policy that directly or indirectly restricts or restrains any individual member’s freedom of choice with respect to professional societies for which they are eligible; (2) urge state medical associations to review and study membership provisions of their bylaws to maintain fair membership standards for equal access for all physicians and medical students; and (3) urge state medical associations to provide all medical students equal access to funding and opportunity within the realm of their society. (MSS Amended Res 10, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

530.024MSS Medical Student Participation in Professional Organizations: AMA-MSS will ask the AMA to work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years. (MSS Res 1, A-10) (AMA Res 604, I-10 Adopted [G-620.050]) (Reaffirmed: MSS GC Rep D, I-15)

530.025MSS Sexual Orientation and Gender Identity Demographic Collection by the AMA and Other Medical Organizations: Our AMA-MSS will ask that our AMA develop a plan with input from the LGBT advisory committee to expand the demographics we collect about our members to include both sexual orientation and gender identity information, which will be given voluntarily by members and handled in a confidential manner. (MSS Res 06, A-16) (AMA Res 603, A-17 Adopted as Amended [updated G-635.125])

535.000MSS AMA: Board of Trustees


535.003MSS Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations: AMA-MSS will ask the AMA to support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders. (MSS Res 16, I-18) (AMA Res 014, A-19, G-620.043)

540.000MSS AMA: Councils and Committees

540.002MSS Council Elections and Visibility: AMA-MSS will retain the appointment process as a means of selecting the student representatives to the AMA Councils with an increased focus on visibility and communication as incontestable components of the Council positions. (Ad Hoc Com. Rep
AMA-MSS Digest of Policy Actions/ 149


550.000MSS AMA: House of Delegates

550.008MSS Medical Student Regional Delegate Apportionment: (1) AMA-MSS will ask the AMA to amend its bylaws such that Medical Student Regional Delegate (RD) and Medical Student Alternate Regional Delegate (AD) positions are allocated at a rate of one RD/AD for every 2,000 medical student members. These allocated RD/AD positions are then apportioned to the seven AMA-MSS Regions at a rate of one RD/AD per 2,000 medical student members within each region, with any remaining allocated RD/AD position(s) being apportioned to the Region(s) with the greatest number of medical student members in excess of a multiple of 2,000; and (2) AMA-MSS will amend its Internal Operating Procedures to reflect any amendments to the AMA Bylaws that affect the allocation or apportionment of Medical Student Regional Delegate and Medical Student Alternate Regional Delegate positions. (MSS GC Rep B, I-10) (AMA Res 605 Adopted, A-11 [D-615.980]) (Reaffirmed: MSS GC Rep D, I-15)

565.000MSS AMA: Political Action


565.002MSS Preserving the AMA’s Grassroots Legislative and Political Mission: AMA-MSS will ask the AMA to ensure that all Washington activities, including lobbying, political education, grassroots communications, and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. (MSS Res 20, A-00) (AMA Res 619, A-00 Adopted [D-640.998]) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

565.003MSS Building AMA-MSS Membership through Promotion of AMPAC and State Medical PACs: (1) AMA-MSS urges all regional delegates to annually recruit for AMPAC and state PAC membership among all medical students from their respective regions; (2) AMA-MSS will ask the AMA to urge all delegates to annually recruit for AMPAC and state PAC membership among all medical student members that they are in contact with; (3) Where state laws permit, AMA-MSS will encourage and will ask the AMA to encourage all medical students (regardless of AMA membership) to join state medical society PACs; (4) AMA-MSS will recognize and will ask the AMA to recognize the state and the medical student region with the highest percentage membership in AMPAC and/or state PACs at each annual meeting. (MSS Res 19, A-03) (AMA Res 616, A-03 Adopted [D-640.995]) (Reaffirmed: MSS Sub Res 36, A-04) (Modified: MSS GC Report A, I-16)

565.004MSS Policy and Advocacy Opportunities for Medical Students: AMA-MSS will ask the AMA to: (1) establish medical student health policy and advocacy elective rotations for medical students based in Washington, DC.; and (2) support and encourage internal, state, and specialty organizations to offer health policy and advocacy opportunities for medical students. (MSS Res 18, I-14)

565.005MSS
630.007MSS **AMA-MSS: Administration and Organization**

**MSS Resolutions:** It is the policy of the AMA-MSS that MSS resolutions, including the “whereas” and “resolve” clauses and footnotes, once submitted to the Department of Medical Student Services may not, with the exception of retyping, be altered by staff or an MSS council or committee prior to the MSS Assembly Meeting without the consent of the author. (MSS Res 12, I-85) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**630.008MSS** **Referencing Data in Resolutions:** It is the policy of the AMA-MSS that all data in resolutions which contain hard facts, figures, and quotes be referenced accordingly, or the resolution be returned to the author for additional information. (MSS Res 28, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

**630.011MSS** **Improved Access and Programming of Non-Scientific Issues in Medicine:** AMA-MSS will: (1) explore better methods of disseminating information from the AMA-MSS to local chapters with the goals of increased access, and program development; and (2) develop a series of modular programs, which can be used by local chapters to educate their members on topics of importance to future physicians, according to the following guidelines: (a) the information must be flexible, dynamic, accessible and cost effective; (b) a variety of topics could be covered, including medical ethics, legal issues in medicine, the lifestyles of various specialties, medicine and the media, medical economics, etc. (MSS Res 14, I-88) (Reaffirmed: MSS Rep B, I-13) (Reaffirmed: MSS Res 43, A-18)

**630.012MSS** **Annual AMA-MSS Budget Statement:** It is the policy of the AMA-MSS that (1) at the Annual meeting the Director of Medical Student Services shall provide the Assembly with a line-term budget for the current fiscal year; and (2) the Director of Medical Student Services will provide the AMA-MSS Governing Council with proposed budget statements at appropriate time during the year in order to facilitate planning and operations of the AMA-MSS. (MSS Res 17, A-89; Referred) (MSS Rep C, A-90, Adopted in Lieu of MSS Res 17, A-89) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**630.016MSS** **MSS Reference Committee Information:** AMA-MSS and the Office of Medical Student Services will release to state delegation chairperson or resolution author, a copy of the AMA-MSS Reference Committee Packet upon such request upon arrival at the AMA-MSS meeting. (MSS Amended Res 7, A-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

**630.019MSS** **MSS Master List of Dates:** AMA-MSS will compile a yearly "Master List of Dates," which will identify important deadlines for MSS and AMA activities and programs which will be available at the Annual MSS Assembly. (MSS Res 22, I-90) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

630.025MSS  Changes in MSS Resolutions Forwarded to the AMA House of Delegates: It is the policy of the AMA-MSS that the MSS Delegate and Alternate Delegate to the AMA House ofDelegates (when they agree) may make grammatical or syntax changes in MSS resolutions before they are forwarded to the House of Delegates, but in no circumstances can the meaning or intent of the MSS resolutions be altered. Further, the MSS Speaker and Vice Speaker must be advised of any change made to an MSS resolution before the resolution is forwarded to the House of Delegates and must concur that the change in grammar or syntax does not alter the meaning or intent of the resolution. The MSS Speaker or Vice Speaker, may not, under any circumstance, initiate the change in grammar or syntax on any MSS resolution. (MSS Res 43, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

630.029MSS  AMA Resource Libraries in Medical Schools: AMA-MSS urges its school delegates to obtain reserve space in their schools' medical libraries to set up an AMA library that would include, but not be limited to, the following documents: the AMA Policy Compendium; the state society Policy Compendium (where available); the most current AMA-HOD Proceedings; the most current AMA-MSS Proceedings; the AMA-MSS Textbook of Legislation; the AMA-MSS Resource Manual; the AMA-MSS Internal Policy and Digest of Actions; Chapter Bylaws; AMA-MSS Policy Documents (e.g. "Sexual Harassment Guidelines"); available national, state, regional, and county society updates and newsletters of at least the immediate past year; and AMA-MSS Program Modules. (MSS Sub Res 20, I-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

630.037MSS  Reaffirmation Calendar: AMA-MSS will implement and use a reaffirmation consent calendar akin to that used by the AMA-HOD and set forth in AMA Policy 545.979 and 545.974, to expedite the business of the Assembly on resolutions seeking reaffirmation of existing AMA-MSS policy. The Reaffirmation Calendar will provide “statements of support” for existing AMA policy for those resolutions deemed identical or nearly identical to existing AMA policy. (MSS Amended Res 17, A-93) (MSS Rep C, I-93) (MSS Amended Rep C, I-97) (Reaffirmed: MSS GC Report A, I-16)


630.044MSS  Sunset Mechanism for AMA-MSS Policy: AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council; (2) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption; (3) a consent calendar format will be used by the Assembly in considering the policies encompassed within
the report; and (4) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism. (COLRP Rep B, I-95) (MSS Amended Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

630.049MSS AMA Medical Student Section Vision Statement: The AMA-MSS supports the following vision statement for the AMA-MSS: (1) The AMA-MSS core purpose is: the AMA-MSS is dedicated to representing medical students, improving medical education, developing leadership and promoting activism for the health of America; (2) The AMA-MSS Envisioned Future is: The AMA-MSS strives to be the medical students’ leading voice for improving medical education, advancing health care and advocating for the future of medicine.; (3) The AMA-MSS Objectives are: (a)The leading medical student organization for advancing issues of public wellness, community service, ethics, and health policy; (b) The principal source for obtaining and disseminating information for medical students regarding medical education, residency training, and medical practice; (3) The most representative voice and influential advocate for medical students and their patients; and (4) A dynamic organization that provides value to its medical student members; and (4) The AMA-MSS Core Values are: (a) Advocacy: Caring advocates for our patients, our profession, and our medical student members. (b) Leadership: The stewards of the future of medicine. (c) Excellence: Commitment to provide the highest quality service, products, and information for our members. (d) Integrity: Ethical behavior forms the basis for trust in all our relationships and actions. (MSS COLRP Rep B, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

630.050MSS Creating a Community Service Project: AMA-MSS will undertake a limited local service project as part of its agenda at its Annual and Interim Meetings, at a time determined by Governing Council, as appropriate based on the schedule of activities. (MSS Sub Res 16, A-98) (Reaffirmed: MSS Rep E, I-03) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

630.051MSS AMA-MSS Digest of Actions: It is the policy of the AMA-MSS that the AMA-MSS Internal Operating Procedures and Digest of Actions be made available on the AMA-MSS Web site, with updates made within two months of each Annual and Interim Meeting of the Assembly. (MSS Sub Res 21, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

630.055MSS Implementation of MSS Policy: AMA-MSS will report at each meeting on the progress of all resolutions passed at the meeting five years previous to the current, especially focusing on action called for by external policies. (MSS Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Amended: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)


630.063MSS Creation of International Health Policy Regional Chairs: AMA-MSS suggests that each region elect or appoint an International Health Policy Committee Regional Chair. (MSS Res 31, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

630.069MSS Developing our Regions: (1) AMA-MSS reaffirms the roles of the Regional Chairs; (2) AMA-MSS recognizes that the roles of the Region are to provide a home within the MSS, to serve as a communication unit for the MSS, to provide a means to foster collaboration between the chapters and states, and to facilitate interaction and integration of newly developing chapters with well-established chapters; (3) AMA-MSS recognizes the Regional Leadership for their
Voting Rights of MSS Speaker and Vice Speaker: Our AMA-MSS (1) will amend its Internal Operating Procedures IV.A by deletion as follows:

A. Designations. The officers of the MSS shall be the eight Governing Council members: Chair, Vice Chair, AMA Delegate, Alternate AMA Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, and Vice Speaker. The Chair-elect/Immediate Past Chair shall be a non-voting member of the Governing Council. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker. The Speaker and Vice Speaker shall be non-voting members of the Governing Council; and

(2) amend its Internal Operating Procedures IV.E by addition and deletion as follows:

1. The Chair-elect/Chair/Immediate Past Chair of the Governing Council shall serve a two-year term. His or her term as Chair-elect will begin at the conclusion of the Interim Meeting at which he or she is elected. He or she will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. He or she will serve as Immediate Past Chair until the conclusion of the following Interim Meeting.

2. The other Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA House of Delegates.

3. Maximum tenure for members of the MSS Governing Council will be two years in any combination of voting or non-voting positions. The periods of service as Chair-elect and Immediate Past Chair shall not count toward the maximum tenure of two years in any combination of voting or non-voting positions.

(MSS GC Res 01, I-16)

Review of AMA-MSS Statements of Support of HOD Policies: (1) The formally-supported policies specified for action in Appendix 1 of this report be acted upon as recommended; and (2) the AMA-MSS Governing Council review the “AMA-MSS Statements of Support for HOD Policies” section of the AMA-MSS Digest of Policy Actions every five years for redundant and outdated statements of support. (MSS GC Report B, A-17)

Pilot Implementation of the 2018 Resolution task Force Recommendations: MSS will:

1. Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and b) Making a video explaining the basics of Parliamentary Procedure and the most common mistakes made;

2. Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as
support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee;

3. Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring all external resolution authors to contact the relevant specialty society prior to submission;

4. Improve transparency of resolution feedback among all actors throughout the resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers to send feedback summary emails to the primary author’s Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;

5. Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC;

6. Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category;

7. Reaffirm its existing process of creating the Assembly’s Order of Business according to quantitative resolution scores;
8. Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; and

9. Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year. (Amended GC Rep A, A-18)

640.000MSS AMA-MSS: Committees

640.001MSS MSS Task Force on Long Range Planning: It is the policy of the AMA-MSS that the Committee on Long Range Planning should be a Committee, appointed by the Governing Council, to study issues referred by the Governing Council as well as structure, function, and strategic planning issues relating to the future of the MSS. (MSS Rep C, A-86) (Reaffirmed: MSS Rep E, I-96, Recs. 1, 7 and 8; Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed, MSS GC Report D, I-11) (Modified: MSS GC Report A, I-16)

640.003MSS States Regional Chairs: AMA-MSS, through Regional Chairs will: (1) continue to encourage the development of local MSS chapters and state MSS sections in medical schools and states where they do not exist; (2) involve highly organized MSS chapters and state sections in providing organizational information and assistance to developing chapters and sections; (3) encourage MSS chapters to maintain communication and interaction between medical student members and physician members of county and state medical societies; and (4) ask the MSS to endorse the maintenance of active and timely communication between MSS delegates and Regional Chairs. (MSS Rep K, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified and Retained: MSS GC Rep D, I-15)

640.008MSS MSS Committee Reports: It is the policy of the AMA-MSS that the AMA-MSS Governing Council may suggest changes to committee reports but may not alter them without consultation with and agreement of the committee. Further, the Governing Council may include an addendum to the committee report, should a dissenting opinion exist, to distinguish the opinions of the Governing Council from those of the committee. (MSS Rep L, I-91, Adopted in lieu of MSS Res 44, A-91) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

640.011MSS Region Chair Elections: AMA-MSS will modify its policy on the Region Chairs to allow for direct election of the Region Chairs by the sections, according to the following guideline: New chairs must be selected before Saturday morning of the annual meeting, and the new chair must be present at the annual meeting. (MSS Rep F, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Rep B, I-09) (Modified: MSS GC Report A, I-16)
AMA-MSS Digest of Policy Actions/ 156

640.013MSS  AMA-MSS Standing Committees: The AMA-MSS Governing Council will: (1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees and report back at I-05; (2) handle requests for funding from MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council’s goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per committee per year. (MSS Rep F, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

640.014MSS  Regional Representation on MSS Committees: The AMA-MSS Governing Council will (1) continue to empower regions and work toward increasing diversity on all MSS Committees by using regional diversity as one of the selection criteria for all MSS Committees. (MSS Amended Sub Res 21, I-07) (GC Rep C, A-10 Filed [640.016MSS]) (Modified and Reaffirmed: MSS GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

[start at 640.017MSS]

645.000MSS  AMA-MSS: MSS Assembly


645.013MSS  Information for the AMA Medical Student Section Assembly Concerning Issues Discussed at the AMA-HOD: AMA-MSS will conduct an open hearing on Saturday at each Annual and Interim meeting, to hear pertinent items of business that will be coming before the AMA-HOD at that meeting. (MSS Sub Res 4, A-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

645.015MSS  Non-Voter Participation During the Assembly Portion of the AMA-MSS Annual and Interim Meetings: (1) AMA-MSS will continue to sponsor a Community Service project during Business Meetings of Medical Student Section. (2) The AMA-MSS Governing Council will: (a) continue to investigate and implement alternative activities for non-voting participants including but not limited to residency fairs, workshops, and lectures; (b) establish a separate convention committee to organize and implement NSP activities during the meetings; and (c) investigate ways to further promote and expand the activities of the sectional meetings. (COLRP Rep B, A-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Modified: MSS GC Rep A, I-16)


645.019MSS  European Medical Student Association (EMSA) – Official Observer: The AMA-MSS will invite the European Medical Students Association to send a non-voting Official Observer to all

645.023MSS | Medical Student Section Policy Making Procedures: (1) As part of its annual review of MSS policies set to sunset at each Interim meeting, the MSS Governing Council will undertake policy consolidation for at least one issue; (2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates; (3) The MSS Governing Council will provide the MSS with updates on actions taken on resolutions and report recommendations adopted by the MSS Assembly, similar in format to the HOD’s “Implementation of Resolutions and Report Recommendations” documents, and that these updates be archived as an historical record of GC actions; (4) AMA-MSS will continue to use a Reaffirmation Consent Calendar, modeling it in the style of the House of Delegates Reaffirmation Consent Calendar; (5) The MSS Governing Council will educate the Section, specifically representatives to the MSS Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar; (6) AMA-MSS will continue to use and enforce the mandatory MSS Resolution Checklist; (7) When MSS policy comes up for sunsetting, the MSS Delegate and Alternate Delegate will, at their discretion, consider re-forwarding to the House of Delegates MSS policy that was previously forwarded but not adopted. (MSS Rep A, A-08) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Modified: MSS GC Report A, I-16)

645.026MSS | Advocating for the Continuation of a Fall Meeting of the Medical Student Section: Due to its critical and unique role in our Section, AMA-MSS will advocate for the continuation of a Fall Meeting of the AMA-MSS that is appropriately resourced to achieve our AMA-MSS’ core mission. (MSS GC Rep C, A-09) (Reaffirmed: MSS GC Rep A, I-14)

645.027MSS | A New Direction for the AMA-MSS Annual Meeting: AMA-MSS study the restructuring of the AMA-MSS Annual and Interim Meetings to meet the programming and policy needs of the AMA-MSS, and report back at A-11. (MSS GC Rep A, I-10) (Reaffirmed: MSS GC Rep D, I-15)

645.031MSS | Policy-making Procedures: (1) A minimum of 90 days before the start of a national MSS meeting, the MSS Delegate and Alternate Delegate, with input from other members of the MSS caucus to the AMA House of Delegates, release a list of several suggested resolution topics based on perceived gaps in the MSS Digest of Actions. (2) A list of all GC Action Items received during the period between MSS national meetings will be included in the Meeting Handbook as official MSS Actions. Additionally, the MSS should create an opportunity for the Governing Council to discuss GC Action Item implementation status with interested students. (3) That Reference Committees be encouraged to recommend GC Action Items in future report reasoning. (4) The MSS Internal Operating Procedures will be amended in order to eliminate the advocacy-only rule. (5) All authored resolutions are submitted to the region of the resolution’s primary author for rough draft scoring using the MSS Scoring Rubric. Following the draft submission deadline, regional delegates and alternate delegates will be assigned specific resolutions, for which they score and subsequently contact the particular resolution’s author to offer feedback and suggestions prior to the MSS final resolution deadline. (6) The MSS Internal Operating Procedures will be revised to require resolutions to be submitted 50 days prior to the start of an Annual or Interim Meeting. (7) All resolutions submitted for MSS consideration by the resolution deadline will be scored blindly by the MSS House Coordinating Committee and the Regional and Alternate Delegates from the 6 regions where the primary author’s school is not located, with each resolution’s average ranking subsequently being released to the author. (8) Our MSS will release detailed resolution formatting rules and an easy to use template for resolution drafting, available on the MSS Resolution Resources page. Resolutions not meeting the formatting guidelines will be returned to the submitting author and not be accepted until properly formatted within the established
Continued Support for the Virtual Reference Committee: AMA-MSS supports the continued implementation and utilization of the Virtual Reference Committee, including the use of online testimony to develop a Reference Committee report prior to each AMA and AMA-MSS national meeting. (MSS Res 9, I-13)

Biennial Review of Organizations Seated in the AMA-MSS Assembly: AMA-MSS (1) retains the following NMSSs and PIMAs as eligible for AMA-MSS Assembly representation: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Association of Physicians of Indian Origin (AAPI), American College of Emergency Physicians (ACEP), American College of Medical Quality (ACMQ), American College of Physicians (ACP), American Society of Anesthesiologists (ASA), American Society of Military Surgeons of the US (AMSUS), and American Medical Women’s Association (AMWA); (2) retains the following NMSOs as eligible for AMA-MSS Assembly representation: American Physician Scientists Association (APSA), Asian Pacific American Medical Student Association (APAMSA), Latino Medical Student Association (LMSA), and Student National Medical Association (SNMA); and (3) recognizes the following NMSO and PIMA organizations as newly seated organizations in the AMA-MSS Assembly: Student Osteopathic Medical Association (SOMA), Psychiatry Student Interest Group Network (PsychSIGN), Association of Native American Medical Students (ANAMS), and Health Professionals Advancing LGBTQ Equality (GLMA). (GC Rep A, A-19)

Systematic Review of AMA-MSS Authored Resolutions in the AMA House of Delegates: AMA-MSS will study the outcomes of MSS resolutions in the AMA House of Delegates including both objective measures of resolution adoption rates as well as subjective measures of the degree to which MSS goals were met regardless of outcome. The AMA-MSS Governing Council, under the direction of the Delegate and Alternate Delegate, consider using the results of the study to continue to improve and update the resolution writing process and report back to the MSS Assembly at intervals deemed appropriate by the AMA-MSS Governing Council. (MSS Res 02, I-17)
655.001MSS  Student Membership in State Medical Societies: AMA-MSS will ask the AMA to: (1) support and encourage student membership and participation in state medical societies; to encourage societies to establish student dues that do not exceed 50 percent of the national student dues; and (2) seek the removal of any impediments to student membership in the AMA or in state or county medical societies.  (AMA Res 92, I-79, Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

655.002MSS  Membership Recruitment Methods: AMA-MSS: (1) endorses the concept that mechanisms of offering medical students free membership in the AMA and/or constituent societies should require direct action by medical students to accept the offer; (2) opposes full subsidization of AMA student dues by constituent societies for more than an initial one-year introductory period for new members; (3) does not oppose partial subsidization of AMA student dues by constituent societies as a positive incentive for medical students to join the AMA; and (4) supports medical student representation in state delegations to the AMA House of Delegates, with the goal of having a proportional number of delegate seats based on student membership.  (MSS Rep I, A-82) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

655.003MSS  Dual State Society Membership for Medical Students: The AMA-MSS Governing Council will ask the Department of Membership to encourage state medical societies to allow medical students to hold membership in the state society in which they attend medical school and also an associates membership in their state of permanent residence and that associate memberships in a state society not be counted in determining the number of AMA delegates representing a state.  (MSS Sub Res 19, I-85) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

655.004MSS  Medical Student Membership Benefits: AMA-MSS will ask the AMA to: (1) acknowledge all new student applications within two weeks of receipt of applications and that this acknowledgment contain the name and a phone number, which may be dialed collect, of an AMA staff member responsible for benefit inquiries and grievances; (2) ensure the distribution of journals to new members within 8 weeks of receipt of applications; and (3) provide benefits, free of charge, to new members processed before January until official membership begins in January according to the AMA calendar.  (AMA Res 127, A-86 Referred) (BOT Rep X, I-86 Filed) (BOT Rep GG, A-88 Filed) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report A, I-16)

655.005MSS  Recruitment Information in AMA and MSS Pamphlets: (1) It is the policy of the AMA-MSS that recruitment literature distributed to students by the AMA and/or MSS clarify that AMA membership does not automatically imply membership in state or county/local medical societies.  (2) AMA-MSS recruitment literature will stress the benefits of membership on the national, state, and county/local levels.  (MSS Res 15, A-86) (Reaffirmed: MSS Rep E, I-96) (Reaffirmed: MSS Rep B, I-01) (Reaffirmed: MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D-I-11) (Reaffirmed: MSS GC Report A, I-16)

655.015MSS  Eligibility of Medical Students to Join the AMA while Enrolled in a Joint Degree Program: AMA-MSS will use peer-to-peer recruitment to identify and recruit, on an individual basis, joint degree students who begin their education in a discipline other than medicine.  (MSS Rep D, I-95, Adopted in lieu of Res 46, A-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

655.018MSS Membership Retention into Residency: AMA-MSS will continue to explore ways to increase awareness of the Medical Student and Resident Fellow Sections in order to increase membership retention during the transition to residency. (MSS COLRP Rep A, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

655.022MSS MD/PhD AMA Membership: AMA-MSS will develop a mechanism for MD/PhD students and other students requiring greater than a 4-year training period to sign up for a longer AMA-MSS membership and make this available on the world wide web. (MSS Amended Res 15, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

655.024MSS Improving Federated Membership Recruitment and Portability: AMA-MSS supports the development of a system whereby medical student, resident/fellow, and young physician members of the AMA, state, and county medical societies may rapidly transfer their new or existing memberships to the appropriate state and county medical societies of their new program or practice. (MSS Sub Res 9, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

655.025MSS Increasing the Efficiency of Student Membership Application Processing: AMA-MSS encourages the AMA to continue its internal evaluation of the procedures involved in the processing of student membership applications and take steps to decrease delays and increase service to medical student applicants and members. (MSS Sub Res 4, A-01) (Amended MSS Rep F, I-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

655.028MSS The Designation of Permanent Membership Positions Within Local AMA-MSS Chapters: AMA-MSS strongly encourages every medical school to designate a permanent position within their chapter to be responsible for matters pertaining to membership recruitment and retention throughout the school year, and that the chapter provide the individual’s name and current mailing address to the AMA Medical Student Section Outreach Program prior to each Annual Meeting. (MSS Res 1, A-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

655.031MSS Reevaluating AMA-MSS Membership Benefits: AMA-MSS will ask the AMA to continue to provide tangible membership benefits for medical students that are both useful and encourage participation in our professional society. (MSS Res 2, I-04) (Modified: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

655.033MSS Establishing a Joint MSS and RFS Approach for Recruitment Initiatives for Incoming MSS Members to the RFS: AMA-MSS will: (1) work with the AMA-RFS to focus membership strategies to retain student members and recruit new resident members; and (2) work with medical school deans to find better means to recruit 4th year medical students to the AMA-RFS including increased presence at match day and graduation events. (MSS Amended Res 5, A-05 Adopted) (Reaffirmed: MSS GC Report A, I-16)

660.000MSS AMA-MSS: Officers - Nomination, Election, and Tenure
Questions of Parliamentary Procedures: (1) The AMA-MSS parliamentarian will be either the Speaker or Vice Speaker, whoever is not presiding over the Assembly. (2) The AMA-MSS Governing Council will appoint a temporary parliamentarian when either the Speaker or Vice Speaker is not present. (MSS Sub Res 5, A-88) (Reaffirmed: MSS Rep F, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13)

Campaign Reform: AMA-MSS encourages all members to recognize the commitments of the candidates at the Interim and Annual meetings and use prudent judgment when inviting them to address group meetings and furthermore strive for fair and equal access to all candidates and all sections, states, and societies. (MSS Amended Sub Res 3, A-97) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Councilor Selections: It is the policy of the AMA-MSS that AMA-MSS Governing Council members shall excuse themselves from all formal and informal Governing Council discussion and selection of any position for which they are candidates. (MSS Amended Res 7, A-05 Adopted) (Reaffirmed: MSS GC Report F, I-10) (Reaffirmed: MSS GC Report D, I-15)

AMA-MSS: Regional Operations

Strengthening of Regional Internal Operating Procedures (IOPs), Creation of Regional Coordinating Committees, and Creation of Membership/Recruitment Chair for Each Region: (1) It is the policy of the AMA-MSS that the following sections within each region’s Internal Operating Procedures be standardized: (a) Name, (b) Purpose and Principles, (c) Membership, (d) Method for Substituting Regional Delegates at the National Meetings, (e) Number of Required Meetings, (f) Quorum, (g) Parliamentary Authority, (h) Amendments, and (i) Supremacy and Severability, while leaving the content of the Elections, Voting, and Committees sections up to each region individually; (2) Region Chairs should work with emerging chapters and create a Membership/Recruitment Chair for their respective region, and (3) Region Chairs should undertake pilot projects to build region funding. (MSS RIT Force Rep A, A-06) (Reaffirmed: MSS GC Report D, I-11) (Modified: MSS GC Report A, I-16)

Evaluation of AMA-MSS Region Bylaws: It is the policy of the AMA-MSS:
1. That all Medical Student Region Bylaws include, at minimum, abbreviated versions of:
   a. The purpose of the Medical Student Region to elect Regional Delegates to the AMA House of Delegates per MSS IOP VIII. A;
   b. The responsibilities of the Region Chair per MSS IOP VIII. A. 3;
   c. An outline of the requirements for Regional Delegate Elections per MSS IOP VIII. B.2;
   d. Descriptions of their Regional Governing Council per MSS IOP VIII. A.4; and
   e. Determination and Responsibilities of the Regional Delegate Chair per MSS IOP VIII. C.
2. That all Medical Student Region Bylaws are in accordance with the prevailing parliamentary code of our AMA per MSS IOP XII.A.
3. That the Speaker or Vice Speaker or his or her designee be authorized to correct article and section designations, punctuation and cross-references, and to make such other
technical and conforming changes as may be necessary to reflect the intent of the MSS with respect to the Medical Student Region bylaws requirements as recommended by this report.

4. That our AMA-MSS reevaluate the content of each Medical Student Region’s bylaws and report back by A-17. (GC Rep D, A-15)

665.013MSS Transforming for Tomorrow: Our GC, in collaboration with AMA-MSS regional leadership, will work to optimize our AMA-MSS regional structure from the perspective of leadership and districting with report back to the AMA-MSS Assembly at A-16. (GC Rep E, A-14)

665.014MSS Evaluating the Value of Region Restructuring (Follow Up): (1) The existing AMA-MSS region structure will remain unchanged and (2) the AMA-MSS assess each region’s membership numbers and degree of engagement with the AMA-MSS at least every 5 years. (MSS GC Report B, I-16)

665.015MSS Reevaluation of AMA-MSS Region Bylaws: (1) AMA-MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and (2) MSS COLRP reevaluate the accordance of each Region’s bylaws with the categories in Tables 1 – 5b and release its findings in an informational report to the Assembly at A-19. (MSS COLRP Report A, A-17)

665.016MSS Amending G-630.140 Lodging, Meeting Venues and Social Functions: AMA-MSS will ask our AMA to amend policy G-630.140 Lodging, Meeting Venues, and Social Functions to read as follows:

Lodging, Meeting Venues, and Social Functions G-630.140

(1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost and similar factors.
(2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel, or in a hotel close in proximity.
(3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances to justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies and other health organizations to adopt a similar policy.
(4) It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including but not limited to, policies based on race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
(5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

(MSS Res 17, A-19)

665.017MSS Re-evaluation of AMA-MSS Region Bylaws: It is the policy of the MSS:
1. That Region 1 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

2. That Region 2 modify their bylaws to specify the responsibilities of the Region Delegation Chair and Region Chair and specify the selection of the Regional Delegate to be in accordance with MSS IOP 8.4, MSS IOP 8.1.3 and MSS IOP 8.3 respectively;

3. That Region 3 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

4. That Region 4 modify their bylaws to include the process in which the Region Chair and, Region Delegates, and Region Delegation Chair are selected and the responsibilities of the Region Delegation Chair and Region Chair to be in accordance with MSS IOP 8.1.3, MSS IOP 8.5, and MSS IOP 8.4;

5. That Region 5 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4;

6. That Region 6 modify their bylaws to include details on the process in which the Region Delegation Chair and Region Delegate is selected and the responsibilities of the Region Delegation Chair and Region Chair, and eliminate the exclusion where the Region Delegation Chair cannot be an Alternate Delegate to be in accordance with MSS IOP 8.1.3, MSS IOP 8.3, and MSS IOP 8.4;

7. That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection and responsibilities on the Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.4; and

8. That our MSS-COLRP re-evaluate the accordance of each Region’s bylaws with the categories in tables 1-5b and release its findings in an informational report to the Assembly at A-21.

(MSS COLRP Rep A, A-19)
AMA-MSS Statements of Support for HOD Policies

Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid: The MSS formally establishes supports for the following AMA policy:

Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid H-305.941
AMA policy is to pursue changes to federal legislation or regulation, and specifically to the Higher Education Act, to change the cost of attendance definition for medical education to include costs for food, shelter, clothing and health care for all dependents, and for dependent care. (Res. 205, I-97; Reaffirmed: CME Rep. 2, A-07)

(MSS Res 9, A-97)

Physician Involvement in the Care for the Uninsured: The MSS formally establishes support for the following HOD policy:

H-160.961 Caring for the Poor
(1) Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients. In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity. Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as: by seeing indigent patients in their offices at no cost or at reduced cost, by serving at freestanding or hospital clinics that treat the poor, and by participating in government programs that deliver health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless. In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor. (2) State, local, and specialty medical societies should help physicians meet their obligations to provide care to the indigent. By working together through their professional organizations, physicians can provide more effective services and reach more patients. Many societies have developed innovative programs and clinics to coordinate care for the indigent by physicians. These efforts can serve as a model for other societies as they assist their members in responding to the needs of the poor.
Disparity in Mental Health Coverage: The MSS formally establishes support for the following HOD policies:

H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs
Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

H-185.986 Nondiscrimination in Health Care Benefits
Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured. (Res. 58, A-91; Reaffirmation A-97; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10)

Skin Cancer Prevention in Children: The MSS formally establishes its support for the following HOD Policies:

H-170.969 Teaching Preventive Self-Examinations to High School Students
The AMA supports the development of comprehensive high school health curricula in conjunction with local medical societies and health departments. This curriculum should include instruction in appropriate self-examinations of the skin, breasts, testes and other systems.

Regulation of Tattoo Artists, Skin Piercers, Facilities: The MSS formally establishes support for the following AMA policies:

H-440.909 Regulation of Tattoo Artists and Facilities
The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program.

H-440.934 Adequacy of Sterilization in Commercial Enterprises
The AMA requests that state medical societies explore with their state health departments the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids.

Infant and Child Safety on Airplanes: The MSS formally establishes support for the following HOD policy:

H-45.989 Child Safety Restraint Use in Aircraft
Our AMA supports (1) the use of appropriate restraint systems for all children on all commercial airline flights; and (2) working with the Federal Aviation Administration to establish criteria for appropriate child restraint systems.

Transparency in Capitation Rate Setting: The MSS formally establishes support for the following HOD policies:

H-180.961 Defining Levels of Health Insurance Coverage
Our AMA strongly encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the Federal Employees Health Benefits Plan program; and supports the enactment of federal and/or state legislation requiring
the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations.

H-285.946 Fair Physician Contracts
Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies; (2) which proprietary "correct coding" CPT bundling program is employed; (3) grievance and appeal mechanisms; (4) conditions under which a contract can be terminated by a physician or health plan; (5) patient confidentiality protections; (6) policies on patient referrals and physician use of consultants; (7) a current listing by name and specialty of the physicians participating in the plan; and (8) a current listing by name of the ancillary service providers participating in the plan.

H-185.979 Allocation of Health Services
The AMA will: (1) work with payer organizations and managed care plans and support legislation as necessary to develop and encourage adherence to a standard format across plans for disclosure of relevant plan information to prospective enrollees; (2) expand its consumer information program to develop guides to assist individuals in understanding health insurance offerings and restrictions so that they can make informed decisions in selecting plans best suited to meet individual and family needs and circumstances; (3) utilize all appropriate consumer health information channels to encourage the development by individuals and families of personal health records containing information on family and medical histories and problems, care received, medications, immunizations, allergies, and other relevant medical information and to explore the feasibility of developing sample formats for such personal health records; and (4) encourage and facilitate the development and distribution to physicians for use in their offices of brochures and other appropriate materials that would address such issues as advance directives, health promotions, alternative medical care and other health care information that might be sought by patients and/or their families.

(MSS Resolution 34, I-99)

Physicians as Role Models of Health Maintenance: The MSS formally establishes support for the following HOD policy:

H-170.995 Healthful Lifestyles
The AMA believes that consumers should be encouraged and assisted to learn healthful practices by: (1) educating and motivating the consumers to adopt more healthful lifestyles; (2) exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles; (3) encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness; and physicians demonstrating these practices through personal examples of health lifestyles.

(MSS Res 8, A-00)

Education Regarding Childhood Obesity: The MSS formally establishes support for the following HOD policy:

H-440.902 Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients.
Physician Education Regarding Benefits of Social Group Therapy for Breast Cancer Patients: The MSS formally establishes support for the following AMA policy:

H-55.999 Symptomatic and Supportive Care for Patients with Cancer
Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate chemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

De-linking Medicaid from Welfare: Room for Improvement: The MSS formally establishes support for the following HOD policy:

H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement
(1) It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs to adult coverage, our American Medical Association urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds. (2) Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.

Protection from Second-Hand Tobacco Smoke at Access Points of Public Buildings: The MSS formally establishes support for the following HOD policy:

H-490.913 Smoke-Free Environments and Workplaces
On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free schools and eliminating smoking in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free environment; (c)
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strongly encourages the owners of family-oriented theme parks to make their parks smoke-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy lifestyle for children; (d) encourages state or local legislation or regulations that prohibit smoking in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking efforts in the prohibition of smoking in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free environment in the military through the use of mechanisms such as health education, smoking cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking in all casinos and gaming venues.

(MSS Res 2, I-02)

Consideration of Humanistic Qualities in Medical School Admissions: The MSS formally establishes support for the following HOD policy:

H-295.888 Progress in Medical Education: The Medical School Admission Process
1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly- educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.  2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

(MSS Res 2, A-03)

Bioterrorism Education in the Medical School Curriculum Prior to Clinical Rotations: The MSS formally establishes support for the following HOD policy

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters
Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters. (2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts. (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post-traumatic stress disorders associated with exposure to disaster, tragedy, and trauma. (4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional’s role in these systems. (5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level. (6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues. (7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters. (8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

(MSS Res 6, A-03)

AMA Support for Manned Space Exploration of the Moon, and Mars that will Promote Medical Research and Enhance Patient Care: The MSS formally establishes support for the following AMA policy:
Continuation of Medical Research on Manned Space Flights H-45.994

1. Our AMA supports the continuation of the NASA and other programs for conducting medical research and other research with potential health care benefits on manned space flights, including the continued development and subsequent operation of the international space station. 2. Our AMA (a) publicly supports the National Aeronautics and Space Administration's new commitment for manned space exploration of the moon, Mars, and other celestial bodies for the benefits to medicine and advances in patient care and (b) supports the continuation of NASA research to accomplish safe, human space exploration as this research has demonstrated and may have potential future benefits to medicine and advances in patient care. (Sub. Res. 118, A-86; Modified by Sub. Res. 217, A-94; Reaffirmed: CSA Rep. 6, A-04; Appended and Reaffirmed: Res. 502, A-07)

(MSS Res 7, I-06)

Encouragement of Medicaid Funding for 17P Progesterone for High Risk Pregnancies: The MSS formally establishes support for the following HOD policies:

H-290.993 Coverage of Drugs by Medicaid
Our AMA (1) urges CMS to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions, even if such drugs are manufactured/distributed by non-rebating firms, and (2) asks CMS to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty.

H-420.972 Prenatal Services to Prevent Low Birthweight Infants
Our AMA encourages all state medical associations and specialty societies to become involved in the promotion of public and private programs that provide education, outreach services, and funding directed at prenatal services for pregnant women, particularly women at risk for delivering low birthweight infants.

H-425.976 Preconception Care
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.

(MSS Res 2, I-07)
Decreasing the Spread of HIV/AIDS in the United States: The MSS formally establishes support for the following HOD policy:

D-20.992 Routine HIV Screening
Our AMA: (1) supports HIV screening policies which include: (a) routine HIV screening of adolescents and adults ages 13-64 and sexually active adults over 65, (b) patients receive an HIV test as a part of General Medical Consent for medical care with option to specifically decline the test, and (c) patients who test positive for HIV receive prompt counseling and treatment as a vital part of screening; (2) supports that the frequency of repeat HIV screening be determined based on physician clinical judgment and consideration of identified risks and prevalent community experience; (3) supports the Centers for Disease Control and Prevention’s (CDC) 2006 Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings; (4) will continue to work with the CDC to implement the revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings, including exploring the publication of a guide on the use of rapid HIV testing in primary care settings; (5) will identify legal and funding barriers to the implementation of the CDC’s HIV testing recommendations and develop strategies to overcome these barriers; (6) will publicize its newly adopted HIV screening policies via its existing professional electronic and print publications and to the public via news releases and commentaries to major media outlets; and (7) will formally request all public and private insurance plans to pay the cost of routine HIV screening testing of all insured individuals who receive routine HIV testing in accordance with new recommendations.

(MSS Res 7, I-07)

Medical School Tuition Caps and Tuition Freezes to Alleviate the Primary Care Physician Shortage in the U.S.: The MSS formally establishes support for the following HOD policies:

D-305.975 Long-Term Solutions to Medical Student Debt
Our AMA will: (1) through its Council on Medical Education, continue a comprehensive study of medical education financing, with a report back to the House of Delegates at the 2005 Annual Meeting; (2) encourage medical schools and state medical societies to consider the creation of self-managed, low-interest loan programs for medical students, and collect and disseminate information on such programs; (3) advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas; (4) work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment; and (5) collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

H-200.973 Increasing the Availability of Primary Care Physicians
It is the policy of the AMA that: (1) Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission and set institutional priorities accordingly. (2) The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties. (3) Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care. (4) Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. (5) All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings. (6) The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged. (7) Medical schools should provide career counseling related to the choice of a primary care specialty. (8) The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of training generalist physicians. (9) There should be increased financial incentives for physicians practicing primary care. (10) Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and
unnecessary paper work should be undertaken. (11) There should be educational support systems for primary care physicians, especially those practicing in underserved areas. (12) States should be encouraged to provide positive incentives--such as scholarship or loan repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

H-200.997 Primary Care
The AMA believes that there should be a sufficient supply of primary care physicians - family physicians, general internists, general pediatricians, and obstetricians/gynecologists. In order to achieve this objective: (1) Voluntary efforts to develop and expand both undergraduate and graduate programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for family practice should be encouraged. (2) Federal support, without coercive terms, should be available to institutions needing financial support for the expansion of resources for both undergraduate and graduate programs designed to increase the number of primary care physicians. (3) It is the policy of the AMA, with representatives of primary care specialty groups and the academic community, to develop recommendations for adequate reimbursement of primary care physicians and improved recruitment of medical school graduates into primary care specialties.

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

(MSS Res 5, I-08)

Interoperable Electronic Medical Records: The Future of a Segmented Health Care System: The MSS formally establishes support for the following HOD policies:

D-478.995 National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EMR user interface design.
specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.

(MSS Res 14, I-08)

Expansion of National Health Services Corps Scholarship and Loan Repayment: The MSS formally establishes support for the following HOD policies:

H-200.984 National Health Service Corps Reauthorization
It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs.

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage
In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians. (3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians. (4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions. (5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas. (6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. (7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program. (8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services. (9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians. (10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages. (11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible. (12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

(MSS Res 16, I-08)

Guidelines for the Reuse of Single Use Devices: The MSS formally establishes support for the following HOD policy:

H-480.959 Reprocessing of Single-Use Medical Devices
Our AMA: (1) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000; (2) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry; (3) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and (4) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.

(MSS Res 10, A-09)

Medical Decision Making for Same-Sex Couples: The MSS formally establishes support for the following HOD policy:

H-140.901 Equity in Health Care for Domestic Partnerships
Our AMA supports legal recognition of domestic partners for hospital visitation rights and as the primary medical care decision maker in the absence of an alternative health care proxy designee.

(MSS Res 13, A-09)

Encouraging Innovative (First in Class) Pharmaceuticals: The MSS formally establishes support for the following HOD policies:

H-460.983 Availability of Funding for Research
(1) Federal funding of basic and applied medical research should be increased at an annual rate of 10 percent (after inflation) for the remainder of the 1980s, and funding in the 1990s should be at a level sufficient to ensure appropriate growth in the nation's biomedical research enterprise. The major recipients of these increases should be the National Institutes of Health, the Veterans Administration, the Alcohol, Drug Abuse and Mental Health Administration, the Food and Drug Administration, and the Centers for Disease Control. (2) The National Institutes of Health, the Alcohol, Drug Abuse and Mental Health Administration, and other granting agencies should fund 40 percent of the approved grant applications each year for the remainder of the 1980s. (3) Appropriate measures to reform patent, tax and licensing laws, as well as measures to enhance the efficiency of regulatory processes, should be adopted by the federal government to encourage private industry involvement in basic and applied biomedical research.

H-110.996 Cost of Prescription Drugs
Our AMA supports increasing physician awareness about the cost of drugs prescribed for their patients.

(MSS Res 14, A-09)

Condoms in Prisons: The MSS formally establishes support for the following HOD policy:

H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in Correctional Facilities
(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes mandatory testing for HIV infection and tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Testing for HIV infection and tuberculosis should be mandatory for all prisoners within 60 days of their release from prison; e) Physicians who practice in correctional institutions should evaluate all tuberculin-positive inmates for HIV infection and all HIV-positive patients for tuberculosis, since HIV status may affect subsequent management of tuberculosis infection or disease and tuberculosis may accompany HIV infection; f) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; g) During their post-test counseling procedures, prison medical directors should encourage HIV-infected inmates to confidentially notify their sexual or needle-sharing partners; and h) Correctional medical care must, as a minimum, meet the prevailing standards of care for HIV-infected persons in the outside community at large. Prisoners should have access to all approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
Rethinking AMA Medical Liability Reform Policy: The MSS formally establishes support for the following HOD policy:

(1) It is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a $250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth. (2) Our AMA also supports federal reform to achieve: (a) a certificate of merit requirement as a prerequisite to filing medical liability cases; (b) statutory criteria that outline expert witness qualifications; and (c) demonstration projects to implement potentially effective alternative dispute resolution (ADR) mechanisms. (3) Our AMA supports medical product liability reform, applicable to the producers of pharmaceuticals and medical devices, as an important state and federal legislative reform objective. (4) Any health system reform proposal that fails to include MICRA type reform, or an alternative model proven to be as effective in a state, will not be successful in containing costs, providing access to health care services, and promoting the quality and safety of health care services. Under no circumstances would support for federal legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers effective state-based reform will be actively opposed.

(MSS Res 14, A-10)

Reevaluation of Elderly Drivers: The MSS formally establishes support for the following HOD policies:

H-15.972 Licensing People to Drive
It is the policy of the AMA (1) to encourage research into the many components and activities of the driving task and into the development of more accurate testing devices; (2) that physicians continue to warn patients about the possibility of untoward side effects from medications, particularly those that might impair driving; (3) that the physician attempt to give competent advice about the wisdom of the patient's driving, while keeping in mind the obligation to protect the community and obey the law; and (4) that the physician, if uncertain about the patient's ability to drive, consider recommending that the state licensing agency arrange a driving test.

H-15.954 Older Driver Safety
(1) Our AMA recognizes that the safety of older drivers is a growing public health concern that is best addressed through multi-sector efforts to optimize vehicle design, the driving environment, and the individual’s driving capabilities, and: (a) believes that because physicians play an essential role in helping patients slow their rate of functional decline, physicians should increase their awareness of the medical conditions, medications, and functional deficits that may impair an individual’s driving performance, and counsel and manage their patients accordingly; (b) encourages physicians to familiarize themselves with driver assessment and rehabilitation options, refer their patients to such programs whenever appropriate, and defer recommendations on permanent driving cessation until establishing that a patient’s driving safety cannot be maintained through medical interventions or driver rehabilitation; (c) urges physicians to know and adhere to their state’s reporting statutes for medically at-risk drivers; and (d) encourages continued scientific investigation into strategies for the assessment and management of driving safety in the clinical setting. (2) Our AMA encourages physicians to use the Physician’s Guide to Assessing and Counseling Older Drivers as an educational tool to assist them in helping their patients.

(MSS Res 21, A-10)

Expanding Graduate Medical Education in Response to the Increase in Medical Student Training: The MSS formally establishes support for the following HOD policies:
H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

It is AMA policy that: (1) Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. (2) Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. (3) Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. (4) Diversified sources of funding should be available to support medical schools’ multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school’s missions. (5) All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding. (6) Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. (7) Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. (9) New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

H-310.917 Securing Funding for Graduate Medical Education

Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.

(MSS Res 8, I-10)

Medical Student Position Regarding the 2010 ACGME Residency Work Standards: The MSS formally establishes support for the following HOD policy:

H-310.979 Resident Physician Working Hours and Supervision

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: ‘The sponsoring institution’s GME Committee must [m]onitor programs’ supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents’ level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation
with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements:

"Counseling services: The Sponsoring Institution should facilitate residents’ access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents’ work that is extraneous to their GME programs’ educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.

(MSS Res 15, I-10)

Opposing Mandatory Treatment of Patients Covered by Government-Funded Health Insurance as a Condition of Physician Licensure: The MSS formally establishes support for the following HOD policies:

H-275.994 Physician Participation in Third Party Payer Programs
The AMA opposes state laws making a physician's licensure contingent upon his providing services to Medicaid beneficiaries or any other specific category of patients should be opposed.

H-275.984 Legislative Action
The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure.

D-275.962 Threat to Medical Licensure
Our AMA will develop model legislation to ensure that medical licensure is independent of participation in any health insurance program.

(MSS Res 19, I-10)

Awareness, Diagnosis, and Treatment of Bipolar Disorder in Youth: The MSS formally establishes support for the following HOD policies:

H-345.981 Access to Mental Health Services
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person’s identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

(MSS Res 21, I-10)
Creating National Standards for Electronic Health Records Systems: The MSS formally establishes support for the following HOD policies:

D-478.996 Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

D-478.994 Health Information Technology
Our AMA will: (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT); (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and (3) support initiatives to ensure interoperability among all HIT systems.

(MSS Res 23, I-10)

AMA Support of Medical Supply Reuse Programs: The MSS formally establishes support for the following HOD policies:

D-250.992 Medical Supply Donations to Foreign Countries
Our AMA will: (1) continue to advertise opportunities for donations on the AMA web site and continue to refer individual physicians to appropriate relief agencies; and (2) continue current relationships with relief organizations.

H-65.994 Medical Care in Countries in Turmoil
The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

H-250.987 Duty-Free Medical Equipment and Supplies Donated to Foreign Countries
Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries.

(MSS Res 24, I-10)

Putting Price Transparency into Practice: The MSS formally establishes support for the following HOD policy:

H-373.998 Patient Information and Choice
Our AMA supports the following principles: (1) Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a
more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. (2) Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. (3) In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees’ information on the amount of payment provided toward each type of service identified as a covered benefit. (4) Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. (5) Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. (6) Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

(MSS Res 25, I-10)

Promoting the Universal Adoption of Electronic Prescription Systems: The MSS formally establishes support for the following HOD policy:

D-120.958 Federal Roadblocks to E-Prescribing
1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form; 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs; 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-Prescribing; 4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions; 5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.

(MSS Res 26, I-10)

Support of Outreach Programs that Utilize Community Leaders to Deliver Culturally-Competent Health Information: The MSS formally establishes support for the following HOD policies:

H-205.997 AMA Statement on Voluntary Health Planning
Our AMA believes that the following principles should be considered in the creation and implementation of a program of voluntary community health planning: (1) Health planning should be the primary function of a collaborative group of community organizations and interested individuals. While a variety of structural modalities may be considered to implement this function, the most common is the creation of an eleemosynary organization by the community to be served. However structured and financed, this "health planning organization" should be created from the mandate of the community to address health needs and priorities in a structured fashion and should be legally incorporated to perform this function. (2) The planning organization must be representative of the community and have the active support and participation of the community to be served, including but not limited to physicians. The proper mix of the participants should be determined by the community served and should be responsive to the priorities of the community. (3) As an entity representing the community-at-large, the planning organization should exhibit the following characteristics: thoroughness, objectivity, integrity, sensitivity to the interests of the community; understanding of health care delivery systems and financing; and accountability to the community served. (4) The planning organization should assume an active positive role in assessing community health and medical needs and should serve as the community's advocate in meeting those needs. The
recommendations of the organization should be advisory and the responsibility for implementing those recommendations should rest with the institutions and entities most directly involved. (5) The organization should serve in an informational and educational role to the community-at-large on such issues as community health status, health care financing, health care costs, and the availability of local health resources. Periodic reports should be provided to the community on these and other significant health care issues. (6) The size and scope of the geographic area to be served is best determined by the community residents based on analysis of such factors as population density, service area of health care institutions and practitioners, geographic and transportation considerations, and should not be arbitrarily defined by existing political boundaries. Regional considerations involving two or more such local planning areas may be best coordinated through a consortium of the local planning organizations as appropriate. (7) The planning organization should function under a constitution and bylaws which, at a minimum, set forth: (a) the major objectives of the organization; (b) a locally accepted process for the election, selection and/or appointment of members to the governing body; (c) a mechanism to preserve account-ability to the community-at-large for the recommendations and actions of the organization, recognizing the accepted principles of confidentiality; and (d) a mechanism for ongoing evaluation of all aspects of the organization's services to the community. (8) Decisions regarding the employment of professional consultants and/or staff are properly those of the governing body of the local organization based on the scope of its activities and financial viability. (9) There should be a substantial commitment from the community-at-large to supporting and financing the operation of the planning organization. This commitment may be expressed through donations of public funds, private funds and general solicitation. Donations of time and expertise may be quite substantive and should be recognized equivalently as community contributions. (10) Government may provide supplemental funding in support of local health planning activities directed toward meeting locally determined goals and objectives. Such supplemental financial assistance from government sources should not diminish or replace the financial or other substantive support of the community. Such supplemental funding should not be accepted without careful consideration of the obligations which may accompany it and a commitment to achieve sufficiency as early as possible. (11) The planning organization should encourage and promote the development of positive incentives to attain the objectives identified by the community and should not have regulatory authority or responsibilities. (12) The protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process and, therefore, should not include the use of regulatory sanctions. (13) Exemption from the antitrust laws should be sought for actions taken to implement recommendations of the planning organization, in furtherance of the objectives identified and approved by the community through the planning process.

(MSS Res 32, I-10)

Testing and Lengthening Drug Expiration Dates: The MSS formally establishes support for the following HOD policy:

H-115.983 Expiration Dates and Beyond-Use Dates of Prescription Drug Products

Our AMA: (1) supports the inclusion of expiration dates on the containers/labels of prescription drug products and recommends that expiration dates be determined by pharmaceutical manufacturers using scientifically based stability testing with subsequent approval by the Food and Drug Administration (FDA); (2) urges the pharmaceutical industry, in collaboration with purchasers, the FDA, and the United States Pharmacopeia (USP), to determine whether lengthening of expiration dates will provide clinical and/or economic benefits or risks for patients and, if this is the case, to conduct longer stability testing on their drug products; (3) recommends that pharmacists place a beyond-use date on the labeling of all prescription medications dispensed to patients, and that the beyond-use date be based on the recommendations in the most recent edition of the United States Pharmacopeia and National Formulary (currently USP 24-NF 19) (official January 1, 2000); and (4) encourages the USP, in collaboration with pharmaceutical manufacturers, pharmacy organizations, and the FDA, to continue to explore the development of appropriate stability tests for the determination of scientifically sound beyond-use dates for repackaged products.

(MSS Res 42, I-10)

Broader Regulation of Direct-to-Consumer Genetic Testing: The MSS formally establishes support for the following HOD policies:
H-460.908 Genomic-Based Personalized Medicine
Our AMA: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing
Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

(MSS Res 45, I-10)

Promoting a Standard Nutrition Education Curriculum for Primary and Secondary School Age Children: The MSS formally establishes support for the following HOD policies:

H-150.996 Nutrition Courses in Medicine
Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools.

H-150.953 Obesity as a Major Public Health Program
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.
Self-Injectable Epinephrine Preparedness in Response to Anaphylaxis: The MSS formally establishes support for the following HOD policies:

H-440.884 Food Allergic Reactions in Schools and Airplanes
Our AMA recommends that all: (1) schools provide increased student and teacher education on the danger of food allergies; (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use.

D-60.976 Childhood Anaphylactic Reactions
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy and Anaphylaxis Network; and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

Improving Access to Subsidized Graduate Student Loans: The MSS formally establishes support for the following HOD policy:

D-305.993 Medical School Financing, Tuition, and Student Debt
(1) The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes. (2) Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts. (3) Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition. (4) Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students. (5) Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians. (6) Our AMA will work with other organizations, including the Association of American Medical Colleges, residency
program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians. (7) Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.

(MSS Res 7, I-11)

Protecting the Doctor-Patient Relationship: The MSS formally establishes support for the following HOD policy:

H-373.995 Government Interference in Patient Counseling
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients. 2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician’s ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients. 3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

(MSS Res 18, I-11)

Closer Monitoring of Emergency Medical Kits on Passenger Aircrafts: The MSS formally establishes support for the following HOD policy:

H-45.981 Improvement in US Airlines Aircraft Emergency Kits
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.

(MSS Res 28, I-11)

Reducing Second-Hand Smoke in Apartment Complexes: The MSS formally establishes support for the following HOD policy:

H-490.907 Tobacco Smoke Exposure of Children in Multi-Unit Housing
Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking adults from tobacco smoke exposure by prohibiting smoking in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking adults from tobacco smoke exposure by prohibiting smoking in multi-unit housing.

(MSS Res 39, I-11)

Physician Position to Novel Tobacco Markets: The MSS formally establishes support for the following HOD policies:

H-495.985 Smokeless Tobacco
Given that the use of smokeless tobacco (snuff and chewing tobacco) is associated with health risks, our AMA: (1) supports publicizing the increasing evidence that the use of snuff or chewing tobacco is associated with adverse health effects and encourages ongoing research to further define the health risks associated with snuff and chewing tobacco, including the risk of developing cardiovascular disease, and the effectiveness of cessation and prevention programs; (2) objects strongly to the introduction of "smokeless" cigarettes; (3) opposes the use of
smokeless tobacco products by persons of all ages; (4) urges that the same requirements and taxes placed on
cigarette sales and advertising be applied to smokeless tobacco products; (5) supports legislation to prohibit the
sale of smokeless tobacco products to minors and encourages states to enforce strictly the prohibition on
purchasing and distributing all tobacco products to individuals under the age of 21 years; (6) supports public and
school educational programs on the health effects of smokeless tobacco products; (7) urges the commissioners of
professional athletic organizations to discourage the open use of smokeless tobacco by professional athletes and
recommends that professional athletes participate in media programs that would discourage the youth of America
from engaging in this harmful habit; and (8) is committed to exerting its influence to limit exposure of young
children and teenagers to advertising for smokeless tobacco and look-alike products, and urges that manufacturers
take steps to diminish the appeal of snuff and chewing tobacco to young persons.

H-495.987 Tobacco Taxes
(1) Our AMA will work for and encourages all levels of the Federation and other interested groups to support
efforts, including education and legislation, to pass increased federal, state, and local excise taxes on tobacco in
order to discourage tobacco use. (2) An increase in federal, state, and local excise taxes for tobacco should
include provisions to make substantial funds available that would be allocated to health care needs and health
education, and for the treatment of those who have already been afflicted by tobacco-caused illness, including
nicotine dependence, and to support counter-advertising efforts. (3) Our AMA continues to support legislation to
reduce or eliminate the tax deduction presently allowed for the advertisement and promotion of tobacco products;
and advocates that the added tax revenues obtained as a result of reducing or eliminating the tobacco
advertising/promotion tax deduction be utilized by the federal government for expansion of health care services,
health promotion and health education.

(MSS Res 40, I-11)

Comprehensive Women’s Healthcare for Professionals during Training: The MSS formally establishes support for the
following HOD policies:

H-295.872 Expansion of Student Health Services
1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical
and mental health services at sites in reasonable proximity to where their education is occurring. 2. Our AMA will
encourage the Liaison Committee on Medical Education to develop an annotation to its standard on medical
student access to preventive and therapeutic health services that includes a specification of the following: a.
Medical students should have timely access to needed preventive and therapeutic medical and mental health
services at sites in reasonable proximity to where their education is occurring. b. Medical students should have
information about where and how to access health services at all locations where training occurs. c. Medical
schools should have policies that permit students to be excused from class or clinical activities to seek needed
care.

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians:
The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are
appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to
pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all
residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive
and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical
students and residents which provides no less than the minimum benefits currently recommended by the AMA for
employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability
insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient
monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount
sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA
for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing
continuation of student disability coverage into the residency period
without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and
fellowship programs to provide access to portable group health and disability insurance, including human
immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians;
(b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.

(MSS Res 5, A-12)

Reimbursement for Addressing Social Determinants of Health in Primary Care: The MSS formally establishes support for the following HOD policy:

H-160.919 Principles of the Patient-Centered Medical Home
1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:
Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient’s family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

(MSS Res 11, A-12)

Cost Transparency through Clinical Report Documentation: The MSS formally establishes support for the following HOD policy:

H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians

Our AMA: (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules; (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans; (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted. (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies; (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and (6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

(MSS Res 15, A-12)

Cancer Screenings to Reduce Health Disparities: The MSS formally establishes support for the following HOD policies:

D-350.996 Strategies for Eliminating Minority Health Care Disparities

Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the
elimination of racial and ethnic health care disparities; and (2) identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

(MSS Res 27, A-12)

Tax Deductions for State Based Health Insurance Exchange Policies: The MSS formally establishes support for the following HOD policies:

H-165.848 Individual Responsibility to Obtain Health Insurance
1. Our AMA will support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. 2. Upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies to obtain health care coverage, our AMA will support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

(MSS GC Rep C, A-12)

Recommending Modified Regulation on Direct-to-Consumer Advertising of Drugs: The MSS formally establishes support for the following HOD policy:

H-105.988 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices:
It is the policy of our AMA: 1. That our AMA considers acceptable only those product-specific DTC advertisements that satisfy the following guidelines: (a) The advertisement should be indication-specific and enhance consumer education about both the drug or implantable medical device and the disease, disorder, or condition for which the drug or device is used. (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug’s or device’s approval for marketing. (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products. (d) The advertisement should not encourage self-diagnosis and self-treatment but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended. (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable. (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient. (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition. (h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed. (i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement. (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved. (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines. 2. That our AMA opposes product-specific DTC advertisements, regardless
of medium, that do not follow the above AMA guidelines. 3. That the FDA review and pre-approve all DTC advertisements for prescription drug or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product. 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective direct regulation of DTC. 5. That DTC advertisements for newly approved prescription drug or implantable medical device products not be run until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTC for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product’s sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it. 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTC advertisements. 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTC, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public. 8. That our AMA supports the concept that when companies engage in DTC, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine. 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-specific DTC and with the Council on Ethical and Judicial Affairs (CEJA) Ethical Opinion E-5.015 and to adhere to the ethical guidance provided in that Opinion. 10. That the Congress should request the Agency for Healthcare Research and Quality (AHRQ) to perform periodic evidence-based reviews of DTC in the United States to determine the impact of DTC on health outcomes and the public health. If DTC is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTC regulation or, if necessary, to prohibit DTC in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution. 11. That our AMA continues to monitor DTC, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTC, as necessary. 12. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other product and are not regulated by the FDA). (BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07)

Eliminating Health Care Disparities for Children with Special Health Care Needs: The MSS formally establishes support for the following HOD policies:

H-165.855 Medical Care for Patients with Low Incomes
It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not
choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy) (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children’s Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities,
congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children’s Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

(MSS Res 28, I-12)

National Institutes of Health and National Science Foundation Funding after Sequestration: The MSS formally establishes support for the following HOD policy:

H-460.926 Funding of Biomedical, Translational, and Clinical Research
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research. (Sub. Res. 507, I-97; Reaffirmed: CSA Rep. 13, I-99; Modified: Res. 503, and Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10)

(MSS Res 1, A-13)

Support for Non-Addictive Nicotine Content Levels in Cigarettes: The MSS formally establishes support for the following HOD policy:

H-495.988 FDA Regulation of Tobacco Products
Our AMA: (1) reaffirms its position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette; (2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (3) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (4) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (5) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (6) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; (7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years; and (8) strongly opposes legislation which would undermine the FDA’s authority to regulate tobacco products and encourages state medical
associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12)

Preventing Violent Intent Trauma Recidivism: The MSS formally establishes support for the following HOD policies:

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
1. Our AMA supports: 1) federal and state research on firearm-related injuries and deaths; 2) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; 3) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; 4) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; 5) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; and 6) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. (Sub. Res. 221, A-13)

H-515.979 Violence as a Public Health Issue
The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 1, A-13)

Over-the-Counter Access to Oral Contraceptives: The MSS formally establishes support for the following HOD policies:

D-75.995 Over-the-Counter Access to Oral Contraceptives
1. Our AMA will recommend to the US Food and Drug Administration that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to over-the-counter for such products. 2. Our AMA encourages the continued study of issues relevant to over-the-counter access for oral contraceptives. (Sub. Res. 507, A-13)

H-170.968 Sexuality Education, Abstinence, and Distribution of Condoms in Schools
Our AMA: (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (e) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) are part of an overall health education program; (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of
Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy. (CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09)

(MSS Res 4, I-13)

Shared Medical Appointments - A Novel Healthcare Model: The MSS formally establishes support for the following HOD policy:

H-160.911 Value of Group Medical Appointments
Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy. (Res. 713, A-13)

(MSS Res 7, I-13)

Eliminating Nonclinical Antibiotic Usage in Livestock: The MSS formally establishes support for the following HOD policies:

D-100.976 Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance
Our AMA will work with interested partners to develop new, or improve existing, FDA guidelines concerning the prudent use of antibiotics in livestock to protect patients from the dangers of antimicrobial resistant pathogens. (Res. 530, A-08)

(MSS Res 14, I-13)

Prevention and Awareness of In-Flight Syncope: The MSS formally establishes support for the following HOD policies:

H-45.979 Air Travel Safety
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; and (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency. (CSA Rep. 5, I-98; Appended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-45.978 In-flight Medical Emergencies
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel
on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies; (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. (CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-45.983 Medical Oxygen Therapy on Scheduled Commercial Air Service
Our AMA (1) supports the accommodation of passengers requiring medical oxygen therapy on scheduled commercial aircraft and in airports; (2) recommends that regulatory agencies, medical specialty societies, commercial air carriers, airport authorities, and other interested parties develop a coordinated system, with uniform guidelines specifying acceptable procedures and equipment for the use of medical oxygen in airports and aboard commercial aircraft, that will permit passengers to schedule oxygen with the least possible administrative and financial difficulty and to have available to them an uninterrupted source of oxygen from departure to destination; and (3) urges that any revised system to improve the accommodation of passengers requiring medical oxygen ensure the safety and security of other airline passengers and airport personnel. (Res. 519, A-95; Amended CSA Rep. 4, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

(MSS Res 18, I-13)

Physician Attire Autonomy: The MSS formally establishes support for the following HOD policy:

H-440.856 Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease
Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume “antimicrobial stewardship,” i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care. (BOT Rep. 3, A-10)

(MSS Res 33, I-13)

Increasing Healthy Food Options in School Lunches for Elementary and Middle School Students: The MSS formally establishes support for the following HOD policies:

H-150.944 Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13)

H-150.962 Quality of School Lunch Program
The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07)

(MSS Res 40, I-13)

AMA Support for Medical Students, Residents, and Faculty Who Provide Breastmilk After Reentry into the Workplace: The MSS formally establishes support for the following HOD policy:

H-245.982 AMA Support for Breastfeeding
(1) Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2005 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians can promote, protect, and support breastfeeding practices; (c)
supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places. (2) Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

(MSS Res 23, A-14)

**Safety Net Hospitals and Need for Disproportionate Share Hospital Funding:** The MSS formally establishes support for the following HOD policy:

D-215.995 Specialty Hospitals and Impact on Health Care

Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities; and (6) continue to monitor the specialty hospital issue and report back to the House of Delegates at the 2005 Annual Meeting. (BOT Rep. 15, I-04; Reaffirmation A-09)

(MSS Res 24, A-14)

**AMA Study on Risk-Based Interest Rates for Federal Student Loans and Creation of “Medical Student” Category in Federal Direct Student Loan Program:** The MSS formally establishes support for the following HOD policy:

D-305.984 Reduction in Student Loan Interest Rates

1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13)
Educating America on Graduate Medical Education: The MSS formally establishes support for the following HOD policy:

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (A) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (B) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (C) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation’s current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare & Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program’s sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (A) train more physicians to meet state and regional workforce needs; (B) train physicians who will practice in physician shortage/underserved areas; or (C) train physicians in undersupplied specialties and subspecialties in the state/region.

18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.

19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.


(MSS Res 2, I-14)

Expanding Supportive Efforts in Pre-K-12 Education for Minorities: The MSS formally establishes support for the following HOD policies:

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

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

(MSS Res 27, I-14)

H-170.985 Science, Technology, Engineering and Mathematics Education

Our AMA is committed to working with other concerned organizations and agencies to improve science, technology, engineering and mathematics (STEM) education and literacy in the nation, and to increase interest in STEM on the part of the nation's youth, particularly underrepresented minorities. (Res. 2, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 514, A-09; Reaffirmed in lieu of Res. 524, A-09; Modified: Res. 516, A-14)
Responding to the Global Drug-Resistant Tuberculosis Pandemic: The MSS formally establishes support for the following HOD policy:

H-440.874 Support of Legislation Regarding Global and Domestic Tuberculosis Control
Our AMA supports federal legislation to increase resources for global and domestic TB control. (Res. 227, A-07)

Advocating for the Further Research and Clinical Implementation of the States of Change Model in Lifestyle Counseling to Fight Obesity: The MSS formally establishes support for the following HOD policy:

H-425.972 Healthy Lifestyles
Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management. (Res. 423, A-12)

NIH Initiatives for Young Researchers: The MSS formally establishes support for the following HOD policy:

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers
Our AMA: (1) continues its strong support for the Medical Scientists Training Program’s stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME Rep. 14, A-09)

Advocating for Optimal Screening and Management of Human Trafficking Victims by Formal Education of Healthcare Professionals on this Issue through Integration of this Topic into Continuing Medical Education Requirements and Undergraduate Medical Curriculum throughout the USA: The MSS formally establishes support for the following HOD policy:

H-65.966 Physicians Response to Victims of Human Trafficking
Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.
Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it’s difficult to know just how extensive the problem of human trafficking is, it’s estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project - In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project: - Operates a 24-hour National Human Trafficking Hotline - Maintains the National Human Trafficking Resource Center, which provides a. An assessment tool for health care professionals b. Online training in recognizing and responding to human trafficking in a health care context c. Speakers and materials for in-person training d. Links to local resources across the country

The Rescue & Restore Campaign - The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department’s Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. (BOT Rep. 20, A-13)

Optimizing Health Care Cost Reduction through Sustainability Education and Implementation: The MSS formally establishes support for the following HOD policy:

H-135.939 Green Initiatives and the Health Care Community

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

FDA Clinical Trial Misconduct Reporting and Transparency: The MSS formally establishes support for the following HOD policies:

H-460.972 Fraud and Misrepresentation in Science

The AMA: (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior; (3) supports the promotion of discussions on the peer review process and the role of the physician investigator; (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct; (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. (CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11)

D-460.970 Access to Clinical Trial Data
Our AMA: (1) urges the Food and Drug Administration to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; and (2) supports the adoption of universal policy by medical journals requiring participating investigators to have independent access to all study data from industry-sponsored trials. (Res. 503, A-14)

(MSS Res 10, A-15)

**Addressing Sexual Violence and Improving American Indian and Alaska Native Women’s Health Outcomes:** The MSS formally establishes support for the following HOD policies:

H-350.976 Improving Health Care of American Indians
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life. (4) American Indian religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (CLRDP Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

H-350.977 Indian Health Service
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) **Indian Population:** (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) **Federal Facilities:** Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) **Manpower:** (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing
education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

H-350.981 AMA Support of American Indian Health Career Opportunities
AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population. (4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12)

(MSS Res 15, A-15)

Support for Mandatory Vaccination: The MSS formally establishes support for the following HOD policy:

H-440.970 Religious Exemptions from Immunizations
Since religious/philosophic exemptions from immunizations endanger not only the health of the unvaccinated individual, but also the health of those in his or her group and the community at large, the AMA (1) encourages state medical associations to seek removal of such exemptions in statutes requiring mandatory immunizations; (2) encourages physicians and state and local medical associations to work with public health officials to inform religious groups and others who object to immunizations of the benefits of vaccinations and the risk to their own health and that of the general public if they refuse to accept them; and (3) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in exempt populations and to intensify efforts to achieve high immunization rates in communities where groups having religious exemptions from immunizations reside. (CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

(MSS Res 21, A-15)

Expansion of Medicaid: The MSS formally establishes support for the following HOD policy:

H-290.966 Medicaid Expansion Options and Alternatives
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap. 2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low-income adult populations. 3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage
and eliminating the coverage gap for low-income adults. 4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site. (CMS Rep. 5, I-14)

(MSS Res 26, A-15)

Advocating for Research to Improve the Effectiveness of Nutrition Labeling at Restaurant Chains: The MSS formally establishes support for the following HOD policy:

H-150.936 Support for Uniform, Evidence-Based Nutritional Rating System
1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers’ purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria. (Res. 424, A-10)

(MSS Res 27, A-15)

Studying Best Practices to Promote Tobacco Cessation for Patients of State Alcohol and Drug Abuse Treatment: The MSS formally establishes support for the following HOD policy:

H-490.917 Physician Responsibilities for Tobacco Cessation
Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA:
(1) encourages physicians to refrain from engaging directly in the commercial production or sale of tobacco products;
(2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth;
(3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health;
(4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and,
where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician; (5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs; (6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and (7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. (CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08; Reaffirmed in lieu of Res. 912, I-12)

(MSS Res 44, A-15)

Supporting the Incorporation of Community-Based Early Detection, Treatment, and Prevention of Psychosis into Mental Health Systems: The MSS formally establishes support for the following HOD policy:

D-345.994 Increasing Detection of Mental Illness and Encouraging Education
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12)

(MSS Res 49, A-15)

Vision Screening before Entering School: The MSS formally establishes support for the following HOD policy:

H-425.977 Encouraging Vision Screenings for Schoolchildren
Our AMA:
(1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment;
(2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and
(3) supports periodic pediatric eye screenings based on American Academy of Pediatrics, American Academy of Family Physicians and American Academy of Ophthalmology evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. (Res. 430, A-05)
Ensuring High Quality Care for All Veterans and Their Families: The MSS formally establishes support for the following HOD policies:

H-510.985 Access to Health Care for Veterans
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans’ health care to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program’s "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation’s veterans.(Sub. Res. 111, A-15)

H-510.991 Veterans Administration Health System
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.(CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

H-510.995 Budgetary and Management Needs of the Veterans Health Administration
Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.(BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)

D-510.999 Veterans Health Administration Health Care System
Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient’s health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA’s payment for prescriptions written by physicians who have no formal affiliation with the VHA.(CMS Rep. 1, A-03; Reaffirmed: CMS Rep. 4, A-13)

H-510.994 Ethics Reform Act of 1989
It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting physicians) from the provisions of the Ethics Reform Act of 1989. (Res. 254, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

Drug Pricing Reform: The MSS formally establishes support for the following HOD policies:

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

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

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

4. Our AMA supports measures that increase price transparency for generic prescription drugs. (Sub. Res. 106, A-15)

H-110.989 Pay for Delay Arrangements by Pharmaceutical Companies
Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States. (Res. 520, A-08; Appended: Res. 222, I-12)

D-330.954 Prescription Drug Prices and Medicare
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14)

(MSS Res 21, I-15)

Youth Health Pipeline Programs Initiative: The MSS formally establishes support for the following HOD policies:

D-200.982 Diversity in the Physician Workforce and Access to Care
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. (CME Rep. 7, A-08; Reaffirmation A-13)

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14)

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

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

H-350.960 Underrepresented Student Access to US Medical Schools
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.(Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

H-350.968 Medical School Faculty Diversity
Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools.(CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09)

H-350.970 Diversity in Medical Education
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.(BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15)

H-350.978 Minorities in the Health Professions
The policy of our AMA is that (1) Each educational institution should accept responsibility for increasing its enrollment of members of underrepresented groups.(2) Programs of education for health professions should devise means of improving retention rates for students from underrepresented groups.(3) Health profession organizations should support the entry of disabled persons to programs of education for the health professions, and programs of health profession education should have established standards concerning the entry of disabled persons.(4) Financial support and advisory services and other support services should be provided to disabled persons in health profession education programs. Assistance to the disabled during the educational process should be provided through special programs funded from public and private sources.(5) Programs of health profession education should join in outreach programs directed at providing information to prospective students and enriching educational programs in secondary and undergraduate schools.(6) Health profession organizations, especially the organizations of professional schools, should establish regular communication with counselors at both the high school and college level as a means of providing accurate and timely information to students about health profession education.(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds.(8) The AMA supports counseling and intervention designed to increase enrollment, retention, and graduation of minority medical students, and supports legislation for increased funding for the HHS Health Careers Opportunities Program.(CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)
Increasing Access to Medical Devices for Insulin-Dependent Diabetics: The MSS formally establishes support for the following HOD policy:

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. (Res. 126, A-14)

Removing Restrictions on Federal Funding for Firearm Violence Research: The MSS formally establishes support for the following HOD policies:

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

Data on Firearm Deaths and Injuries H-145.984
The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System. (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Epidemiology of Firearm Injuries D-145.999
Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms. (Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

Support for Equal Healthcare Access for Eating Disorders: The MSS formally establishes support for the following HOD policy:

Eating Disorders H-150.965
The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors. (Res. 417, A-92; Appended by Res. 503, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

(MSS Res 20, A-16)

Gun Violence as a Public Health Crisis: The MSS formally establishes support for the following AMA policy:

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

(Late Res 1011, A-16)

Decreasing Polypharmacy Among Elderly Patients: The MSS formally establishes support for the following HOD policy:

Improving the Quality of Geriatric Pharmacotherapy H-100.968
Our AMA believes that the Food and Drug Administration should encourage manufacturers to develop low dose formulations of medications commonly used by older patients in order to meet the special needs of this group; require geriatric-relevant labeling for over-the-counter medications; provide incentives to pharmaceutical manufacturers to better study medication effects in the frail elderly and oldest-old in pre- and post-marketing clinical trials; and establish mechanisms for data collection, monitoring, and analysis of medication-related problems by age group. (CSA Rep. 5, A-02; Reaffirmation A-10)

(MSS Res 23, I-16)

Addressing Physician and Patient Gaps in Opioid Education: The MSS formally establishes support for the following HOD policies:

Protection for Physicians Who Prescribe Pain Medication H-120.960
Our AMA supports the following: (1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.


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; and 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. (Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15)

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
   A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
   B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
   2. Our AMA:
      A. promotes physician training and competence on the proper use of controlled substances;
      B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
      C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening;
      D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
   3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

(MSS Res 24, I-16)

Informed Consent for Medical School Applicants: Addressing Medical Student Applicant’s Understanding of Burnout:
The MSS formally establishes support for the following HOD policy:

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students. 2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. 3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. 4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. 5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements. 6. Our AMA encourages the utilization of mindfulness education as an effective
intervention to address the problem of medical student and physician burnout. (CME Rep. 8, A-07; Modified: Res. 919, I-11)

(MSS Res 26, I-16)

**AMA-MSS Support of the Movement for Black Lives**: The MSS formally establishes support for the following HOD policy:

**Racial and Ethnic Disparities in Health Care H-350.974**
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. The AMA emphasizes three approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. CLRDPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12

(MSS Res 27, I-16)

**Ultrasound Education in Preclinical Curricula**: The MSS formally establishes support for the following HOD policy:

**Diagnostic Ultrasound Utilization and Education H-480.950**
Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. (Res. 507, A-12)

(MSS Res 29, I-16)

**Non-Behavioral Methods of Diabetes Prevention in At-Risk Populations**: The MSS formally establishes support for the following HOD policies:

**Expansion of National Diabetes Prevention Program H-440.844**
Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. (Sub. Res. 911, I-12)

Strategies to Increase Diabetes Awareness D-440.935
Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence. (Res. 412, A-13)

(MSS Res 33, I-16)

Integration of Telemedicine into Medical Education: The MSS formally establishes support for the following HOD policy:

Telemedicine in Medical Education D-295.313

1. Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. 2. Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. 3. Our AMA encourages the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to include core competencies in telemedicine in undergraduate medical education and graduate medical education training. (CME Rep. 06, A-16)

(MSS Res 39, I-16)

Encouraging Lifestyle Medicine in Undergraduate Medical Education: The MSS formally establishes support for the following HOD policy:

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted. (2) Employers should provide, and employees should participate in programs on health awareness, safety and the use of health care benefit packages. (3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite. (4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse. (5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities. (6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care. (7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community. (8) Information on health and health care should be presented in an accurate and objective manner. (9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula. (10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market. (11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs. (12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services. (13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.
Human Rights as the Foundation of Public Health: The MSS formally establishes support for the following HOD policy:

World Health Organization H-250.992

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible. (BOT Rep. 31, A-96; Reaffirmed: CLRDPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16)

Economic Sustainability and Improved Usage of Health Information Exchanges: The MSS formally establishes support for the following HOD policies:

Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities D-478.981

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits. (Res. 827, I-10; Reaffirmed: 1-13)

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Health Information Technology H-478.994
Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

Information Technology Standards and Costs D-478.996
Our AMA will:
(1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;
(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;
(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;
(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and
(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

(MSS Res 25, A-17)

Increase Access to HIV PrEP for At-Risk Individuals: The MSS formally establishes support for the following HOD policy:

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

(MSS Res 26, A-17)

Protecting the Integrity of Phase III Clinical Trials: The MSS formally establishes support for the following HOD policies:

FDA H-100.992
(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or post-market incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and
post-market reports shows that the drug is unsafe and/or ineffective for its labeled indications.

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

(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10)

FDA Drug Safety Policies D-100.978

Our AMA will monitor and respond, as appropriate, to the implementation of the drug safety provisions of the Food and Drug Administration Amendments Act of 2007 (FDAAA; P.L. 110-85) so that the Food and Drug Administration can more effectively ensure the safety of drug products for our patients. (Sub. Res. 505, A-08; Reaffirmation A-16)

Food and Drug Administration H-100.980

(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. (Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16)

(MSS Res 32, A-17)

Promoting Education on How to Evaluate Asylum Seekers for Signs of Physical and/or Psychological Torture: The MSS formally establishes support for the following HOD policies:

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin, or any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. (CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17)

Human Rights H-65.997


Human Rights and Health Professionals H-65.981

(MSS Res 48, A-17)

Review of AMA-MSS Statements of Support for HOD Policies: The MSS formally establishes support for the following HOD policies:

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed in lieu of: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17)

Umbilical Cord Blood Transplantation: The Current Scientific Understanding H-370.961

Our AMA will: (1) encourage continued research into the scientific issues surrounding the use of umbilical cord blood-derived hematopoietic stem cells for transplantation, including the ex vivo expansion of umbilical cord blood-derived hematopoietic stem cells; the combination of multiple units of closely matched, unrelated umbilical cord blood cells for transplantation; and the improvement of umbilical cord blood cells collection techniques; and (2) support education for physicians and the public about the potential benefits of, and limitations to, umbilical cord blood transplantation as an alternative to bone marrow transplantation. (CSA Rep. 2, A-03; Modified: CSAPH Rep. 1, A-13; Reaffirmed in lieu of: Res. 002, I-16)

9.6.2 Gifts to Physicians from Industry

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

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.
To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:
(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians’ treatment recommendations.
(b) Decline any gifts for which reciprocity is expected or implied.
(c) Accept an in-kind gift for the physician’s practice only when the gift:
   (i) will directly benefit patients, including patient education; and
   (ii) is of minimal value.
(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students’, residents’, and fellows’ participation in professional meetings, including educational meetings, provided:
   (i) the program identifies recipients based on independent institutional criteria; and
   (ii) funds are distributed to recipients without specific attribution to sponsors.

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients’ skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. (CCB/CLRPD Rep. 3, A-14)

Safe Disposal of Used Syringes, Needles and Other Sharps in the Community H-95.942
1. Our AMA recognizes that used sharps in the community pose a public health hazard in diverse ways to workers and to the public.
2. The AMA requests manufacturers of disposable hypodermic needles and syringes to adopt designs to prevent reuse, and to include in the packaging clear directions for their correct disposal.
3. Our AMA continues to support the mission of the Coalition for Safe Community Needle Disposal. (CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 914, I-16)

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term. (CCB/CLRPD Rep. 3, A-14)

(GC Report B, A-17)

Establishing Tax Benefits for Living Organ Donors: The MSS formally establishes support for the following HOD policy:

Methods to Increase the US Organ Donor Pool H-370.959
In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically
low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. (BOT Rep. 13, A-15; Reaffirmed in lieu of: Res. 002, I-16; Modified: CSAPH Rep. 02, I-17)

(MSS Res 39, I-17)

Addressing the Rise of Medical School Tuition: The MSS formally establishes support for the following HOD policy:

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:
   A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
   B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
   C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
   D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
   E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
   F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
   G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
   H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
   I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.


(MSS Res 60, I-17)
Increasing Access to Healthcare Insurance for Refugee Populations: The MSS formally establishes support for the following HOD policy:

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees. (Res. 006, A-17)

(MSS Committee on Global and Public Health Report A, I-17)

Evaluation on Researching Non-Judicial Enforcement of Medicaid Rate Challenges Under 42 U.S.C Section 1396A(A) (30)(a) in Wake of Armstrong V. Exceptional Child Center, Inc.: The MSS formally establishes support for the following HOD policy:

Affordable Care Act Medicaid Expansion H-290.965
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits. (CMS Rep. 02, A-16; Reaffirmation: A-17)

(MSS Committee on Economics and Quality in Medicine Report A, I-17)

Reducing Maternal Tobacco Use During Pregnancy: The MSS formally establishes support for the following HOD policy:

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.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record. (Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17) (MSS Res 24, I-18)

Encouraging Development of Physician Liability Guidelines in Telemedicine: The MSS formally establishes support for the following HOD policy:

Telemedicine H-480.968
The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16)

(MSS Res 26, I-18)

Advocate to End Child Marriage in the United States: The MSS formally establishes support for the following HOD policy:

AMA Support for the United Nations Convention on The Rights of the Child H-60.952

(MSS Res 31, I-18)
End Punitive Measures for Pregnant Women Who Use Drugs: The MSS formally establishes support for the following HOD policy:

Drug Testing H-95.985
Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:
1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.
3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.
4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued. (CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 01, I-16)

(MSS Res 36, I-18)

Provision of Longitudinal Medical Care to Babies, Mothers, and Caregivers Impacted by Substance Use and Exposure: The MSS formally establishes support for the following HOD policy:

Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration 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 use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09)

(MSS Res 39, I-18)

Addressing Disparities Related to Breast Cancer Differences between African American Women and Other Women: The MSS formally establishes support for the following HOD policy:

Cancer and Health Care Disparities Among Minority Women D-55.997
Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. (Res. 509, A-08; Modified: CSAPH Rep. 01, A-18)

(MSS Res 44, I-18)

Amendment to H-170.967 and D-60.994 for Inclusion of Comprehensive Sexual Health Education for Incarcerated Juveniles: The MSS formally establishes support for the following HOD policy:

Health Status of Detained and Incarcerated Youth H-60.986
Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;
(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.
(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.
(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system. (CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16)

(MSS Res 46, I-18)

Implementing Elective Rotations and Increasing Exposure to Prisons into the Medical Education Curriculum: The MSS formally establishes support for the following HOD policy:

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
1. Our AMA encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.
5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties. (CME Rep. 11, A-09; Reaffirmed: CME Rep. 03, I-18)

(MSS Res 48, I-18)

Increasing Education regarding Transition Planning for Children with Chronic Health Conditions, not Limited to Those with Developmental Disabilities: The MSS formally establishes support for the following HOD policy:

Children and Youth with Disabilities H-60.974
It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities;
(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;
(3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;
(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities receive appropriate school health services;
(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities and their families to plan and make the transition to the adult medical care system;
(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and
(7) to encourage physicians to make their offices accessible to patients with disabilities, especially when doing office construction and renovations. (CSA Rep. J, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)

(MSS Res 52, I-18)

Addressing Medical Data Vulnerabilities in Bluetooth and Other Short-Range Wireless Technologies: The MSS formally establishes support for the following HOD policies:

Medical Device Safety and Physician Responsibility H-480.972
The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use. (Res. 507, I-95; Res. 509, A-96; Appended Res. 504, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Use of Wireless Radio-Frequency Devices in Hospitals H-215.972
Our AMA encourages: (1) collaborative efforts of the Food and Drug Administration, American Hospital Association, American Society for Healthcare Engineering, Association for the Advancement of Medical Instrumentation, Emergency Care Research Institute, and other appropriate organizations to develop consistent guidelines for the use of wireless radio-frequency transmitters (e.g., cellular telephones, two-way radios) in hospitals and standards for medical equipment and device manufacturers to ensure electromagnetic compatibility
between radio-frequency transmitters and medical devices; and that our AMA work with these organizations to increase awareness among physicians and patients about electromagnetic compatibility and electromagnetic interference in hospital environments;
(2) hospital administrators to work with their clinical/biomedical engineering staff, safety committees, and other appropriate personnel to adopt and implement informed policies and procedures for (a) managing the use of wireless radio-frequency sources in the hospital, particularly in critical patient care areas; (b) educating staff, patients, and visitors about risks of electromagnetic interference (EMI); (c) reporting actual or suspected EMI problems; and (d) testing medical devices for susceptibility to EMI when electromagnetic compatibility information is lacking;
(3) medical device and electronic product manufacturers to design and test their products in conformance with current electromagnetic immunity standards and inform users about possible symptoms of electromagnetic interference (EMI). If a possibility of EMI problems affecting medical devices exists, steps should be taken to ensure that all sources of electromagnetic energy are kept at sufficient distance; and
(4) physicians to become knowledgeable about electromagnetic compatibility and electromagnetic interference (EMI), recognize EMI as a potential problem in hospital environments, and report suspected EMI problems to the Food and Drug Administration MedWatch program or appropriate hospital personnel. (CSA Rep. 4, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

(MSS Res 58, I-18)

Enhancing Education and Reducing Advertising of Alcoholic Beverages: The MSS formally establishes support for the following HOD policy:

Alcohol and Youth D-170.998
Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (Res. 415, I-01; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18)

(MSS Res 60, I-18)

Protect People Who Use Drugs from Prosecution in the Event of Overdose: The MSS formally establishes support for the following HOD 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)

(MSS Res 63, I-18)

Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication: The MSS formally establishes support for the following HOD policies:

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and
clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.


EHR Interoperability D-478.972

Our AMA:

(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;

(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;

(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;

(4) will continue efforts to promote interoperability of EHRs and clinical registries;

(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;

(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;

(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;

(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18)

(MSS Committee on Health Information Technology Report A, I-18)

Blockchain in Healthcare: Industry Challenges and Opportunities for Emerging Decentralized Technologies: The MSS formally establishes support for the following HOD policy:

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
Encouraging Mental Health First Aid in the Community: The MSS formally establishes support for the following HOD policies:

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. (Res. 923, I-15; Appended: Res. 220, I-18)

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. (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; Reaffirmation: A-19)

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16)
Integrating Immigrant Rights Training into Residency Education: The MSS formally establishes support for the following HOD policy:

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities. (Res. 232, I-17)

(MSS Res 14, A-19)

Emergency Department Observation Units (EDOUs): A Step Toward Reducing Healthcare Costs: The MSS formally establishes support for the following HOD policy:

Emergency Department Boarding and Crowding H-130.940
Our AMA:
1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. (CMS Rep. 3, A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: BOT Rep. 16, A-19)

(MSS Res 15, A-19)

Reducing Unnecessary Postoperative Labs: The MSS formally establishes support for the following HOD policies:

Comparative Effectiveness Research D-460.973
Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency. (Res. 221, A-11)

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians’ professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients’ and other individuals’ privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. (BOT Rep. 41, A-18)

(MSS Res 22, A-19)

Advocate for a Global Carbon Pricing System: The MSS formally establishes support for the following HOD policy:

Global Climate Change - The "Greenhouse Effect" H-135.977
Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;
(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;
(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;
(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and
(5) encourages humanitarian measures to limit the burgeoning increase in world population. (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

(MSS Res 25, A-19)

Liver Transplant Guidelines Regarding Patients with History of Psychiatric Disorders: The MSS formally establishes support for the following HOD policies:

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.
(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.
(3) Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

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

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

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


Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. (Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18)

(MSS Res 27, A-19)

Increased Coverage for HPV Vaccination: The MSS formally establishes support for the following HOD policies:

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

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

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. (Res. 503, A-07; Appended: Res. 6, A-12)

Insurance Coverage for HPV Vaccine D-440.955
Our AMA:
(1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations. (Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16)

(MSS Res 32, A-19)

Curtailing Greenhouse Gas Emissions to Net Zero in the Health Sector: The MSS formally establishes support for the following HOD policies:
AMA Advocacy for Environmental Sustainability and Climate H-135.923
Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. (Res. 924, I-16)

Global Climate Change and Human Health H-135.938
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18)

Transgender and Intersex Care Training for School Health Professionals

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the
medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18)

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18)

(MSS Resolution 40, A-19)