

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801  
(I-19)

Introduced by: Medical Student Section

Subject: Reimbursement for Post-Exposure Protocol for Needlestick Injuries

Referred to: Reference Committee J  
(\_\_\_\_\_, Chair)

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Whereas, Needlestick injuries (NSI) occur in a clinical setting and introduce the risk of transmitting bloodborne pathogens such as Hepatitis B, Hepatitis C, and HIV<sup>1</sup>; and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates that about 385,000 sharps-related injuries occur annually among health care workers with medical students also at risk of sustaining NSIs<sup>2,3</sup>; and

Whereas, Due to the risk of contracting aforementioned bloodborne pathogens, the protocol for NSIs is to receive the appropriate post-exposure prophylaxis (PEP) as a means of disease prevention with appropriate diagnostic follow up<sup>2,3</sup>; and

Whereas, According to recommendations from the International Antiviral Society, the protocol for PEP of HIV specifically for health care workers includes at least 4 weeks of three antiretroviral drug regimen with appropriate laboratory and clinical follow up<sup>3</sup>; and

Whereas, A systematic review that analyzed the costs associated with NSIs among healthcare workers found these costs to range from \$650 to \$750, while also noting extraneous factors, such as time lost at work, that led to variations in costs<sup>4</sup>; and

Whereas, The review also noted that frequent changes in the indicated antiretroviral therapy further leads to a greater variation and increase in costs, with an approximated median cost of \$1,187<sup>4</sup>; and

Whereas, A cost analysis published by the Kaiser Family Foundation indicated that since 2014, the prices of branded common and specialty drugs have risen by 60% and 57%, respectively<sup>5</sup>; and

Whereas, In addition to presenting a significant financial implication, aforementioned processes related to PEP potentially create a severe emotional burden on those who sustain such an injury<sup>1,2,4</sup>; and

Whereas, Many NSIs often go unreported, with studies citing the fear of punishment, the financial costs, and the "time consuming process" as a major factor for not immediately reporting an injury<sup>2,6-8</sup>; and

Whereas, Health care workers that sustain NSI are required to undergo appropriate protocol for exposure, of which all related costs are financially covered under their employer's workers' compensation program<sup>9</sup>; and

Whereas, While these programs vary by state, medical students are often exempt from the mandatory coverage of workers' compensation that their institution offer to health care workers since they are not considered employees<sup>10</sup>; and

Whereas, As an exception to this, the state of Utah amended policy 53B-14-401 to include medical students within its definition of "interns" stating that interns can become recipients of medical benefits from workers' compensation in the event of occupational injuries and diseases<sup>11</sup>; and

Whereas, Although a majority of medical schools require medical students to have a form of health insurance prior to matriculation, the comprehensive costs associated with NSIs are not explicitly stated, and insurance providers inconsistently provide complete coverage of these costs<sup>4</sup>; and

Whereas, Existing AMA policy addresses the costs and debts associated with undergraduate medical education (H-305.925); therefore be it

RESOLVED, That our American Medical Association 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 fund, where applicable (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage state societies to work with their respective workers' compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action)

Fiscal Note:

Received: 08/28/19

#### References:

1. Cooke, C.E., Stephens, J.M. Clinical, economic, and humanistic burden of needlestick injuries in healthcare workers. *Medical Devices: Evidence and Research*. 2017; 10: 225-235.
2. National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. Stop Sticks Campaign.
3. Marrazzo, J.M., et al. HIV Prevention in Clinical Care Settings. *JAMA*. 2014; 312(4): 390-409.
4. Mannocci, A. et al. How Much do Needlestick Injuries Cost? A Systematic Review of the Economic Evaluations of Needlestick and Sharps Injuries Among Healthcare Personnel. *Infection Control and Hospital Epidemiology*. 2016 Jun.; 37(6): 635-646.
5. Kamal, R., et al. What are the recent and forecasted trends in prescription drug spending? *Kaiser Family Foundation*. 2019 Feb 20.
6. Choi, L.Y. et al. Sharps and Needlestick Injuries Among Medical Students, Surgical Residents, Faculty, and Operating Room Staff at a Single Academic Institution. *Journal of Surgical Education*. 2017 Jan.-Feb.; 74(1):131-6.
7. Lauer, A.C. et al. Needlestick and sharp injuries among medical undergraduate students. *American Journal of Infection Control*. 2014 Mar.; 42(3):235-9.
8. Hasak, J.M. et al. Prevalence of Needlestick Injuries, Attitude Changes, and Prevention Practices Over 12 Years in an Urban Academic Hospital Surgery Department. *Annals of Surgery*. 2018 Feb.; 267(2):291-6.
9. Worker Safety in Hospitals. *Occupational Safety and Health Administration*. [https://www.osha.gov/dsg/hospitals/understanding\\_problem.html](https://www.osha.gov/dsg/hospitals/understanding_problem.html). Accessed 19 Apr 2019.
10. Workers' Compensation Law - State by State Comparison. *National Federation of Independent Business*. 2017 Jun 07.
11. Utah Code. Title 53B, Chapter 16, 401-403. [https://le.utah.gov/xcode/Title53B/Chapter16/C53B-16-P4\\_1800010118000101.pdf](https://le.utah.gov/xcode/Title53B/Chapter16/C53B-16-P4_1800010118000101.pdf). Accessed 17 Apr 2019.

#### RELEVANT AMA POLICY

##### Insurance Coverage for Medical Students and Resident Physicians H-295.942

1. Our AMA urges 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. Our AMA urges 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. Our AMA urges 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. Our AMA 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.
  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.
- Citation: (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14)

#### **HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970**

1. Our AMA recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis.
  2. Our AMA 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.
- Citation: (Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

#### **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.
- Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

#### **Prophylaxis for Medical Students Exposed to Bloodborne Pathogens D-365.999**

1. Our AMA will work with the Department of Health and Human Services to seek that references to "staff" in the proposed conditions of participation for hospitals expressly include "students and/or trainees" before they are finalized.
2. Our AMA is unsuccessful in achieving the desired outcome in Recommendation 1, our AMA will work with OSHA to obtain a clarifying interpretation of the current OSHA requirements that would have the effect of broadening the application of their bloodborne pathogen standards to include medical students and trainees.
3. Our AMA is unsuccessful in fulfilling Recommendation 2, our AMA will develop model legislation to establish new standards to ensure appropriate prophylaxis and counseling are made available to medical students and trainees exposed to bloodborne pathogens.
4. Our AMA will make a concerted effort to encourage medical schools to require, as part of their affiliation agreements with medical centers, that CDC and other applicable guidelines and standards be applied also to medical students and trainees. Additionally, Our AMA draft and disseminate model contract language for medical schools to use when contracting with hospitals. And further, Our AMA incorporate an effective enforcement mechanism into the model contract language.

### **Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases H-20.906**

#### **1. Health Insurance**

A currently held health insurance policy of a healthcare worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.

#### **2. Disability Coverage**

a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;

b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;

c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.

Citation: (BOT Rep. 21, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

### **Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925**

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.

9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).

10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.

11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.

12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on



PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19;